

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	0	1	6	5	3	1		
1. FOR STATE REGISTRAR										REG. NO.								
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ARTHUR HAMMOND AMICK										2a. DATE OF DEATH MONTH DAY YEAR JULY 3, 1980				2b. HOUR 11:30 P <sub>M</sub>				
3 SEX Male			4 RACE White			5 DATE OF BIRTH MONTH DAY YEAR July 8, 1893			6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.			7. UNDER 1 YEAR MONTHS DAYS		7. UNDER 24 HRS HOURS MIN				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? U. S. A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.									
10 CITY OR TOWN OF DEATH CUMBERLAND,			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sec. Bldg. & Loan			12b. KIND OF BUSINESS OR INDUSTRY Mortgage Co.					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Allegany 13c. CITY OR TOWN Cumberland,										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Hillcrest Drive,						
14 FATHER'S NAME FIRST MIDDLE LAST Arthur H. Amick										15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillia C. Smith								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes.										16b. SOCIAL SECURITY NO. W.W. # 1 82A 220-03-7713			17 INFORMANT ADDRESS Mr. Miles S. Amick, 310 Nat. Hwy. LaVale, Md. 21502					
18 CAUSE OF DEATH (Enter only one cause for item 18a and 18b) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1539 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Chronic Myocardial Infarction</i> (c) <i>Arteriosclerosis of coronaries of heart -&gt; of obstruction</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2. SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Arteriosclerosis</i>																		
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) May 26 80			21f. LOCATION STREET CITY OR TOWN COUNTY STATE July 3 80					
22a. I certify that I (this hospital) and the deceased from above, (I (we) did) (did not) view the body after death.										22b. SIGNATURE Dr. Terry Williams			DEGREE M.D.			22c. DATE SIGNED 7-4-80		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. TERRY WILLIAMS										22e. ADDRESS MEMORIAL MEDICAL BLDG. CUMBERLAND, MD. 21502								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial										23b. DATE 7/7/80			23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery, JUL			23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland, Allegany Maryland		
24 FUNERAL DIRECTOR H. Wayne George 202 Greene St. Cumberland, Md.										25a. DATE REC'D. BY REGISTRAR JUL 10 1980			25b. REGISTRAR'S SIGNATURE [Signature]					

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11:30 JULY 5, 1990 AMTICU UNKNOWN AS THUR

July 4, 1990

Memorial Hospital

CUMBERLAND, MD 21502

Memorial Hospital

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7-4-90

MEMORIAL MEDICAL BLDG.  
CUMBERLAND, MD 21502

DR. TERRY WILLIAMS

Memorial Hospital

Memorial Hospital

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

1 6 5 3 2

FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>ERNEST B. BARNES</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JULY 27, 1980</b>		2b. HOUR <b>1:28P</b> AM						
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>June 23, 1902</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD					
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN HOME, GIVE STREET ADDRESS) <b>MEMORIAL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ret. Engineer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Cumberland</b>		14. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		15. STREET ADDRESS <b>Rt. #8, Knob Road</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Woodrow Barnes</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Darcus Cooper</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>705-10-8473</b>		17. INFORMANT ADDRESS <b>Melvin L. Barnes, Hagerstown, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer of testis</b> <b>1990</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Primary Site Undetermined</b> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 wks</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): <b>Acute Respiratory Insufficiency Chronic Obstructive Lung Disease</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from <b>1908</b> , 19____, to <b>27 July</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>27 July</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>William P. Iames</b>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>7/28/80</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. WILLIAM P. IAMES</b>		22e. ADDRESS <b>441 N. CENTRE STREET CUMBERLAND, MD. 21502</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>July 30, 80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Union Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Centerville, Bedford, Penna.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUL 31 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Anthony McNeely</b>	
24. FUNERAL DIRECTOR NAME <b>William G. Kight</b>		ADDRESS <b>Cumberland, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUL 31 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Anthony McNeely</b>		25c. DATE REC'D. BY REGISTRAR <b>JUL 31 1980</b>		25d. REGISTRAR'S SIGNATURE <b>Anthony McNeely</b>	

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JULY 25, 1980

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EARLY

CUMBERLAND MEMORIAL HOSPITAL

441 N. CENTRE STREET  
CUMBERLAND, MD. 21502

DR. WILLIAM D. LONG



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		8 0 - 1 6 5 3 3 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) WATSON		FIRST LEO	MIDDLE BENNETT	2a. DATE OF DEATH MONTH DAY YEAR JULY 30, 1980	
3 SEX Male		4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR April 27, 1918	2b. HOUR 5:15 P.M.	
6a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U. S. A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.	
10 CITY OR TOWN OF DEATH CUMBERLAND., MD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Custodian	
13a. STATE Maryland		13b. COUNTY Allegany	13c. CITY OR TOWN Cumberland,	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST Bruce		MIDDLE P.	LAST Benett	15. MOTHER'S MAIDEN NAME FIRST Agnes MIDDLE C. LAST Smith	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes,		16b. SOCIAL SECURITY NO W. W. # 2 217-10-1038		17 INFORMANT ADDRESS Watson L. Bennett by: Prearrangement,	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u> Ventricular Tachycardia + fibrillation</u> 410-- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>Aortic Stenosis / Insufficiency</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Dr. Amado P. Torres</u> DEGREE				22c. DATE SIGNED	
23a. PHYSICIAN'S NAME (TYPE OR PRINT) DR. AMADO P. TORRES				23b. ADDRESS MEMORIAL HOSPITAL MEDICAL BLDG. CUMBERLAND, MD. 21502	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/2/80		23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park,	
24. FUNERAL DIRECTOR NAME H. Wayne George		24b. ADDRESS 21502 Cumberland, Md.		25a. DATE REC'D. BY REGISTRAR AUG 11 1980	
24c. CITY OR TOWN Cumberland		24d. COUNTY Allegany		24e. STATE Maryland	

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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(VR A15 ME (5))  
15M 7/77

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST Orville	MIDDLE P.	LAST Borror	2a. DATE KNOWN OF DEATH XX MONTH DAY YEAR 7-16-80 11 30p M		2b. HOUR
3 SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 04-01-17	6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD 7-16-80 19 11 30p M		2d. HOUR	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Va.	7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD				
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital---DOA				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OR WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE W. Va.		13b. COUNTY Hampshire		13c. CITY OR TOWN Springfield	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS Rt. #1, Box 46			
14. FATHER'S NAME FIRST MIDDLE LAST Unknown		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lela Borror		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No					
16b. SOCIAL SECURITY NO. 214-07-2083		17. INFORMANT Lela B. James Fort Ashby W. Va.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <del>XXXX</del> CORONARY OCCLUSION 410 - Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) CORONARY THROMBOSIS (c) ----- PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE Benedict Skitarelic		TITLE (SPECIFY) Deputy					DATE SIGNED 7-16-80		
EXAMINER'S NAME (TYPE OR PRINT) Benedict Skitarelic, M.D.		ADDRESS #9, Cumberland, Maryland, 21502							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/19/80		23c. NAME OF CEMETERY OR CREMATORY Lohmansville Cemetery Lohmansville, W. Va.		23d. LOCATION CITY OR TOWN COUNTY STATE Grant			
24. FUNERAL DIRECTOR NAME Schaeffer, Petersburg, West Virginia		25a. DATE REC'D. BY REGISTRAR JUL 22 1980		25b. REGISTRAR'S SIGNATURE					

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## MEDICAL CERTIFICATION

Item 18b G546 8/20/80 dad

FOR  
1- STATE REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 0 1 6 5 3 5  
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Manley J. Broadwater</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>July 9 1980</b>			2b. HOUR P M <b>5 40 M</b>	
3 SEX <b>MALE</b>		4 RACE <b>WHITE</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>2 26 97</b>		6 AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>83</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Arlington, Md</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany County</b> MD.	
10 CITY OR TOWN OF DEATH <b>Frostburg</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Frostburg Village Nursing Home</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Carpenter</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>SELF EMPLOYED</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>Maryland</b>		13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Cumberland</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Peter Broadwater</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Meda Garlitz</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO <b>214-07-0590</b>	
17 INFORMANT <b>Patient's Chart</b>		18 ADDRESS					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>3599</b> IMMEDIATE CAUSE (a) <b>Respiratory failure</b> DUE TO, OR AS A CONSEQUENCE OF <b>Idiopathic</b> (b) <b>Chronic myopathy</b> DUE TO, OR AS A CONSEQUENCE OF <b>ASCVD</b> (c) <b>ASCVD</b>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>Dec 29 19 78</b> to <b>July 9 19 80</b> , that (I) (we) lost <b>July 9 19 80</b> and that (a) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. <b>Natural</b>							
22b. SIGNATURE <b>Shirley E. Kim</b>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Shirley E. Kim</b>		22e. ADDRESS <b>90 Main St. Westport Md 21162</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>JULY 12, 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>SUNSET MEMORIAL PARK</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>CUMBERLAND ALLEGANY MD.</b>	
24. FUNERAL DIRECTOR <b>DURST FUNERAL HOME, FROSTBURG, MD.</b>		ADDRESS		25a. DATE REC'D. BY REGISTRAR <b>JUL 16 1980</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 0 1 6 5 3 6	
1. FOR STATE REGISTRAR					REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) HENRY HAROLD BURGESS					2a. DATE OF DEATH MONTH DAY YEAR JULY 1, 1980				2b. HOUR 12:45A		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 14, 1908		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W.Va.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY, MD.					
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Painter		12b. KIND OF BUSINESS OR INDUSTRY Painting			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE W.Va.		13b. COUNTY Mineral		13c. CITY OR TOWN Keyser		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1330 Beacon Street			
14. FATHER'S NAME FIRST MIDDLE LAST Jobe Burgess				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Shillingburg							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO 232-26-1996		17. INFORMANT ADDRESS Mrs. Mary Burgess, 1330 Beacon St., Keyser, W.Va.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): <i>Carcinoma of the esophagus</i> 1579 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <i>Carcinoma of the pancreas</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Carcinoma of the pancreas</i> DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <i>Intestinal obstruction &amp; resection</i>											
19a. DATE OF OPERATION 14 June 80		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Obstruction</i>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 19 <i>78</i> to <i>1 July 1980</i> , that (I) (we) last saw the deceased alive on <i>30 June 1980</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Frederick Miltenberger</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <i>7 July 80</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) FREDERICK MILTENBERGER, M.D.				22e. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD. 21502							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE July 3, 1980		23c. NAME OF CEMETERY OR CREMATORY Potomac Mem. Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Keyser Mineral W.Va.					
24. FUNERAL DIRECTOR NAME MARKWOOD FUNERAL HOME				ADDRESS 111 MINERAL ST., KEYSER, W.VA.				25a. DATE REC'D BY REGISTRAR JUL 10 1980			
								25b. REGISTRAR'S SIGNATURE			



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8016537	
1. FOR STATE REGISTRAR		1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ROY L. BURKETT</b>				2a DATE OF DEATH MONTH DAY YEAR <b>JULY 5, 1980</b>			2b HOUR <b>1:55A M</b>		
3 SEX <b>MALE</b>		4 RACE <b>WHITE</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>SEPT. 6, 1895</b>		6 AGE (IN YEARS LAST BIRTHDAY) YRS <b>84</b>		7 IF UNDER 1 YEAR MONTHS DAYS <b>0 0</b>		8 IF UNDER 24 HRS HOURS MIN <b>0 0</b>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>ALLEGANY COUNTY, MD.</b>					
10 CITY OR TOWN OF DEATH <b>CUMBERLAND</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SACRED HEART HOSPITAL</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>AUTO DEALER</b>		12b KIND OF BUSINESS OR INDUSTRY <b>OWN BUSINESS</b>			
13a STATE <b>MARYLAND</b>		13b COUNTY <b>ALLEGANY</b>		13c CITY OR TOWN <b>LA VALE</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <b>1026 NATIONAL HIGHWAY</b>			
14 FATHER'S NAME FIRST MIDDLE LAST <b>JOHN BURKETT</b>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MATILDA McFARLAND</b>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b SOCIAL SECURITY NO. <b>220-30-8319</b>		17 INFORMANT ADDRESS <b>MRS. IRENE BURKETT, LA VALE, MD.</b>							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Intestinal Obstruction</u> <b>1991</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Malignancy type unknown</u> (c) <u></u> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 W</u> <u>one</u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>ASCVD - CHF Prescribed</u>											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE <u>[Signature]</u> DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c DATE SIGNED <b>7-11-80</b>			
22d PHYSICIAN'S NAME (TYPE OR PRINT)				22e ADDRESS <b>BMG-912 SETON DRIVE., CUMBERLAND, MD. 21502</b>							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b DATE <b>JULY 7 '80</b>		23c NAME OF CEMETERY OR CREMATORY <b>ECKHART CEMETERY</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>ECKHART, MD.</b>					
24 FUNERAL DIRECTOR <b>DURST FUNERAL HOME, 57 FROST AVE., FROSTBURG, MD.</b>				25a DATE RECEIVED BY REGISTRAR <b>JUL 16 1980</b>		25b REGISTRAR'S SIGNATURE <u>[Signature]</u>					

BOEHART, MD.

BOEHART COMPANY

JUN 7 '80

BOEHART

MRS. IRVING BOEHART, LA VALE, MD.

250-30-8319

NO

JOHN

BURNETT

MATILDA

MARYLAND

MARYLAND

ALLEGANY

LA VALE

1000 NATIONAL HIGHWAY

CUMBERLAND

SAVED FROM DESTRUCTION

AUTO DEALER

OWN BUSINESS

MARYLAND

U.S.A.

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SEPT. 6, 1895

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be dated for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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## MEDICAL CERTIFICATION

1- FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		8 0 1 6 5 3 8		REG. NO.	
1 DECEASED NAME (TYPE OR PRINT)		FIRST GRACE MIDDLE HELEN LAST BURNS		2a DATE OF DEATH MONTH DAY YEAR		JULY 29, 1980	
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)	
Female		White		Oct. 20, 1896		83 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH	
Maryland		USA				Allegany MD.	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
CUMBERLAND		MEMORIAL HOSPITAL		Housewife		Own Home	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Md.		Allegany		Cumberland		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO	
Michael D. Martin		Margaret Mc Geady		no			
17 INFORMANT ADDRESS		Mr. James M. Burns, Baltimore, Md. Son					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myelomonocytic leukemia</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2059 DUE TO, OR AS A CONSEQUENCE OF (b) _____							?
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <i>ASCVD, CHF, Pneumonia, renal</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 7/13, 1980, to 7/29, 1980, that (I) (we) last saw the deceased alive on 7/29, 1980, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Dr. Anthony J. Bollino</i>				DEGREE <i>MD</i>		22c. DATE SIGNED 7/29/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. ANTHONY J. BOLLINO, JR.				22e. ADDRESS 955 FREDERICK STREET CUMBERLAND, MD. 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		Aug. 1, 1980		SS. Peter & Paul Cem.		Cumberland Allegany Md.	
24 FUNERAL DIRECTOR NAME James F. Scarpelli				ADDRESS Cumberland, Md.		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR SIGNATURE	
				AUG 04 1980		<i>Anthony Scarpelli</i>	

GRACE	HELEN	BURNS	JULY 20, 1930	4:05P
Female	White	Oct. 20, 1930	63	
Albany	Albany			
CUMBERLAND	MEMORIAL HOSPITAL	Knoxville	Gen. Hosp.	
Albany	Cumberland	x	201 Cumberland St.	
Michael D. Smith	Marshall Co. Ga.			
no	Dr. James H. Brown, Albany, Ill. Gen			

*Referring to...*

ASCD; 197, 198, 199, 200

00 212 214 0 215 216 217 218 219 220 221 222 223 224 225 226 227 228 229 230 231 232 233 234 235 236 237 238 239 240 241 242 243 244 245 246 247 248 249 250 251 252 253 254 255 256 257 258 259 260 261 262 263 264 265 266 267 268 269 270 271 272 273 274 275 276 277 278 279 280 281 282 283 284 285 286 287 288 289 290 291 292 293 294 295 296 297 298 299 300 301 302 303 304 305 306 307 308 309 310 311 312 313 314 315 316 317 318 319 320 321 322 323 324 325 326 327 328 329 330 331 332 333 334 335 336 337 338 339 340 341 342 343 344 345 346 347 348 349 350 351 352 353 354 355 356 357 358 359 360 361 362 363 364 365 366 367 368 369 370 371 372 373 374 375 376 377 378 379 380 381 382 383 384 385 386 387 388 389 390 391 392 393 394 395 396 397 398 399 400 401 402 403 404 405 406 407 408 409 410 411 412 413 414 415 416 417 418 419 420 421 422 423 424 425 426 427 428 429 430 431 432 433 434 435 436 437 438 439 440 441 442 443 444 445 446 447 448 449 450 451 452 453 454 455 456 457 458 459 460 461 462 463 464 465 466 467 468 469 470 471 472 473 474 475 476 477 478 479 480 481 482 483 484 485 486 487 488 489 490 491 492 493 494 495 496 497 498 499 500 501 502 503 504 505 506 507 508 509 510 511 512 513 514 515 516 517 518 519 520 521 522 523 524 525 526 527 528 529 530 531 532 533 534 535 536 537 538 539 540 541 542 543 544 545 546 547 548 549 550 551 552 553 554 555 556 557 558 559 560 561 562 563 564 565 566 567 568 569 570 571 572 573 574 575 576 577 578 579 580 581 582 583 584 585 586 587 588 589 590 591 592 593 594 595 596 597 598 599 600 601 602 603 604 605 606 607 608 609 610 611 612 613 614 615 616 617 618 619 620 621 622 623 624 625 626 627 628 629 630 631 632 633 634 635 636 637 638 639 640 641 642 643 644 645 646 647 648 649 650 651 652 653 654 655 656 657 658 659 660 661 662 663 664 665 666 667 668 669 670 671 672 673 674 675 676 677 678 679 680 681 682 683 684 685 686 687 688 689 690 691 692 693 694 695 696 697 698 699 700 701 702 703 704 705 706 707 708 709 710 711 712 713 714 715 716 717 718 719 720 721 722 723 724 725 726 727 728 729 730 731 732 733 734 735 736 737 738 739 740 741 742 743 744 745 746 747 748 749 750 751 752 753 754 755 756 757 758 759 760 761 762 763 764 765 766 767 768 769 770 771 772 773 774 775 776 777 778 779 780 781 782 783 784 785 786 787 788 789 790 791 792 793 794 795 796 797 798 799 800 801 802 803 804 805 806 807 808 809 810 811 812 813 814 815 816 817 818 819 820 821 822 823 824 825 826 827 828 829 830 831 832 833 834 835 836 837 838 839 840 841 842 843 844 845 846 847 848 849 850 851 852 853 854 855 856 857 858 859 860 861 862 863 864 865 866 867 868 869 870 871 872 873 874 875 876 877 878 879 880 881 882 883 884 885 886 887 888 889 890 891 892 893 894 895 896 897 898 899 900 901 902 903 904 905 906 907 908 909 910 911 912 913 914 915 916 917 918 919 920 921 922 923 924 925 926 927 928 929 930 931 932 933 934 935 936 937 938 939 940 941 942 943 944 945 946 947 948 949 950 951 952 953 954 955 956 957 958 959 960 961 962 963 964 965 966 967 968 969 970 971 972 973 974 975 976 977 978 979 980 981 982 983 984 985 986 987 988 989 990 991 992 993 994 995 996 997 998 999 1000

DR. ANTHONY J. BOLLINO, JR.  
 625 FREDERICK STREET  
 CUMBERLAND, MD. 21502

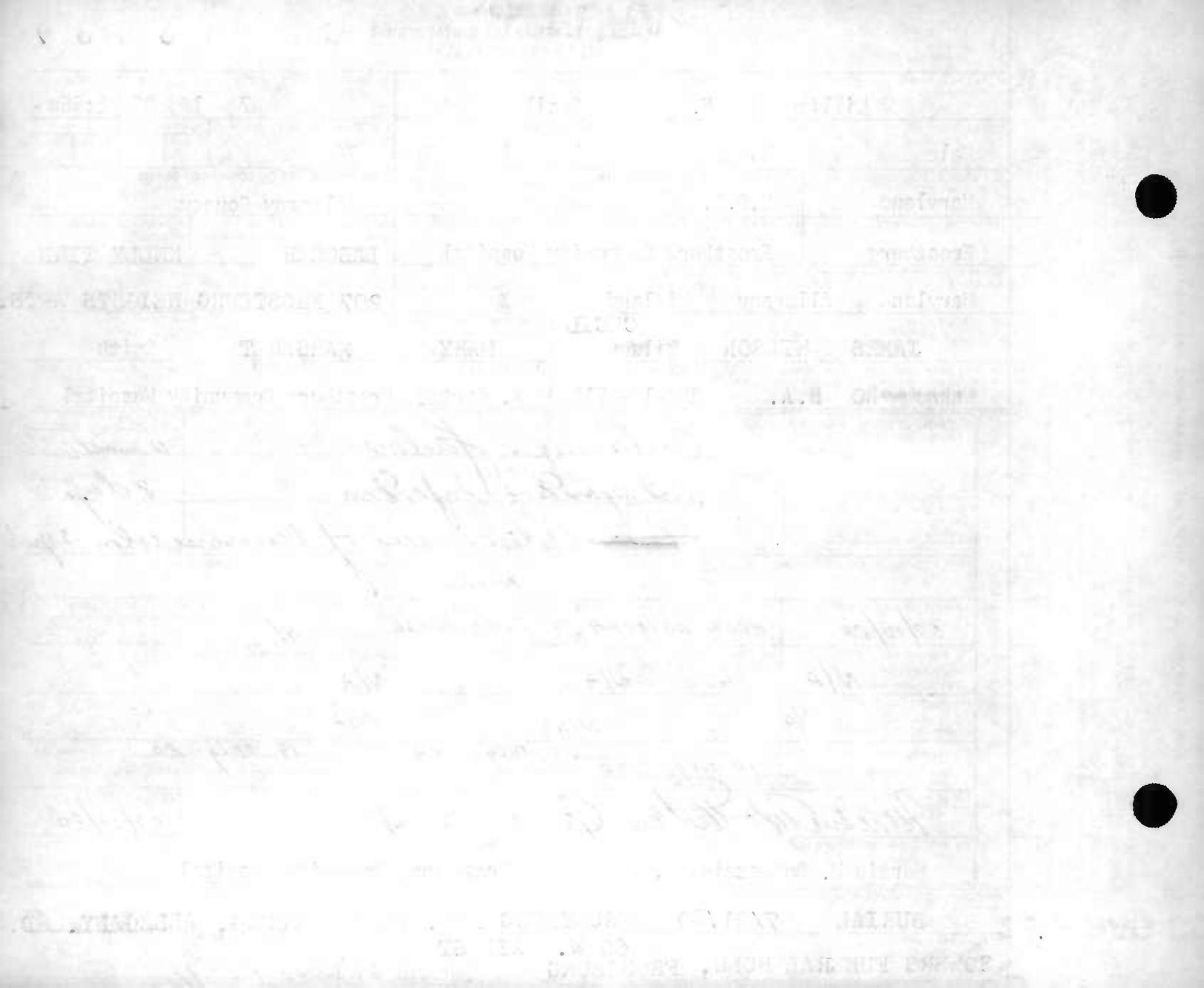
James T. McGeehan  
 Cumberland, Md.  
 Aug. 1, 1970 88, Peter  
 Albany, Albany, Md.  
 AUG 04 1970

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8016539	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST William		MIDDLE F.		LAST Cecil		2a. DATE OF DEATH MONTH DAY YEAR 07 19 80		2b. HOUR 2:55p M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 16 03		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany County MD.					
10. CITY OR TOWN OF DEATH Frostburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frostburg Community Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABORER		12b. KIND OF BUSINESS OR INDUSTRY KELLY TIRE			
13a. STATE Maryland				13b. COUNTY Allegany		13c. CITY OR TOWN Midland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 207 FROSTBURG HEIGHTS APTS.	
14. FATHER'S NAME FIRST MIDDLE LAST JAMES WILSON Wilson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY MARGARET Smith							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) *****NO N.A.				16b. SOCIAL SECURITY NO. 220-10-2719		17. INFORMANT ADDRESS K. Carter, Frostburg Community Hospital					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-resp. failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Post operative infection:</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Adenocarcinoma of Transverse colon 3 yrs?</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <u>none</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 minutes?</u> <u>8 days?</u>	
19a. DATE OF OPERATION 07/10/80		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED ADENOCARCINOMA OF TRANSVERSE COLON				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) N/A		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. N/A 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) N/A							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK N/A		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) N/A		21f. LOCATION STREET CITY OR TOWN COUNTY STATE N/A							
22a. I certify that (I) (this hospital) attended the deceased from <u>07 JULY 1980</u> to <u>19 JULY 1980</u> , that (I) (we) lost saw the deceased alive on <u>19 JULY 1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Martin M. Rothstein M.D.</u>				DEGREE M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 07/20/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Martin M. Rothstein, M.D.				22e. ADDRESS Frostburg Community Hospital							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 7/21/80		23c. NAME OF CEMETERY OR CREMATORY FROSTBURG MEM. PK FROSTBURG, ALLEGANY, MD.		23d. LOCATION CITY OR TOWN COUNTY STATE					
24. FUNERAL DIRECTOR NAME SOWERS FUNERAL HOME, FROSTBURG				ADDRESS 60 W. MAIN ST		25a. DATE REC'D. BY REGISTRAR JUL 23 1980		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			





DMMH - 17  
(VR A15 ME (5))  
15M 7/76

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 1. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			2b. DATE ESTI- MATED			2c. DATE PRONOUNCED DEAD			2d. DATE PRONOUNCED DEAD		
FIRST William			MIDDLE Harvey			LAST Clayton			X MONTH DAY YEAR July 17, 1980			P. M.		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 15, 1907		6. AGE (IN YEARS) (LAST BIRTHDAY) 72 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2e. DATE PRONOUNCED DEAD		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Va.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany			MD.			2f. DATE PRONOUNCED DEAD		
10. CITY OR TOWN OF DEATH Cumberland,		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) D. O. A. Memorial Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales Rep.				12b. KIND OF BUSINESS OR INDUSTRY Sewing Machine Co.				
13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland,		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 528 Columbia Ave.						
14. FATHER'S NAME FIRST MIDDLE LAST John Harvey Clayton				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susan Esther Hill				16a. WAS DECEASED EVER IN U. S. ARMED FORCES? (YES, NO, OR UNKNOWN) No,						
16b. SOCIAL SECURITY NO 217-14-4737				17. INFORMANT Mrs. Justina H. Clayton, 528 Columbia Ave.						ADDRESS Cumb. Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>410-</u> Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. CORONARY OCCLUSION DUE TO, OR AS A CONSEQUENCE OF (b) <u>CORONARY SCLEROSIS,</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>---</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SUDDEN		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I a.														
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET		CITY OR TOWN		COUNTY		
22a. I certify that I took charge of the remains described above, held on				Autopsy <input type="checkbox"/>		Inspection <input checked="" type="checkbox"/>		Inquiry <input checked="" type="checkbox"/>		and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>				TITLE (SPECIFY) Deputy				MEDICAL EXAMINER				DATE SIGNED 7/17/80		
EXAMINER'S NAME (TYPE OR PRINT) <u>Benedict Skitarelic, M. D.</u>				ADDRESS <u>Rt. # 9 Cumberland, Md. 21502</u>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				23b. DATE 7/20/80		23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park,				23d. LOCATION CITY OR TOWN Cumberland, Allegany Maryland				
24. FUNERAL DIRECTOR NAME H. Wayne George				ADDRESS 202 Greene St. Cumberland, Md.				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				

JUL 23 1980



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0 1 6 5 4 1			
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
Joseph H. Crowe				7-1-80			
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)	
Male		Caucasian		6-23-583		97	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH	
Gorietto, Md.		America USA				Allegany MD.	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
Frostburg		Frostburg Community Hospital		retired			
13a STATE				13b COUNTY		13c CITY OR TOWN	
Frostburg				Allegany			
14 FATHER'S NAME				15. MOTHER'S MAIDEN NAME			
Unknown				Jane Crowe			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS	
no				213-24-6655		Mrs. Minne Custer Frostburg	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Myocardial infarction acute							
DUE TO, OR AS A CONSEQUENCE OF (b) DSCVD. Organ brain Syndrome							
DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Artery Disease, Gouty arthritis							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		HOUR A.M. MONTH DAY YEAR					
21d INJURY OCCURRED		21e PLACE OF INJURY		21f LOCATION			
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from June 24, 1980, to July 1, 1980, that (I) (we) lost saw the deceased alive on July 1, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE				DEGREE		22c DATE SIGNED	
Dr. S Kim / Dr. J. Tan				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
22d PHYSICIAN'S NAME (TYPE OR PRINT)				22e ADDRESS			
Dr. S Kim / Dr. J. Tan							
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION	
Burial		7/4/80		Crowe Cemetery		COUNTY STATE	
						Garrett Md	
24 FUNERAL DIRECTOR				25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
Eichhorn's of Lonaconing				JUL 8 1980		[Signature]	

35-52-2

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG NO

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>Flora F. Davis</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>7-19-80</i>			2b. HOUR <i>2:05</i> M			
3 SEX <i>Female</i>		4 RACE <i>White</i>		5 DATE OF BIRTH DAY MONTH YEAR <i>March 18, 1895</i>		6 AGE (IN YEARS LAST BIRTHDAY) <i>85</i>		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>New York</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>Allegany</i> MD			
10 CITY OR TOWN OF DEATH <i>Cumberland</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Cumberland Nursing Home</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i> 13b. CITY OR TOWN <i>Cumberland</i> 13c. STREET ADDRESS <i>306 N. Bel Air Drive</i>					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
14 FATHER'S NAME FIRST MIDDLE LAST <i>Freeman Frost</i>					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Effie Cole</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>			16b. SOCIAL SECURITY NO.		17 INFORMANT ADDRESS <i>Rev. Everett R. Davis, Cumb., Md.</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>COPD.</i> <i>496-</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <i>CHF.</i>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <i>7/17</i> 19 <i>80</i> to <i>7/19</i> 19 <i>80</i> , that (I) (we) last saw the deceased alive on <i>7/18</i> 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) find the body after death.									
22b. SIGNATURE <i>P. HAZMOS</i>			DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>7/20/80</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>P. HAZMOS</i>			22e. ADDRESS <i>302 Schley St Cumberland, Md</i>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>7/23/80</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Rushford Memorial</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Rushford, New York</i>		
24 FUNERAL DIRECTOR NAME <i>Philip B. Wendt</i>					24b. ADDRESS <i>121 Memorial Ave., Cumb., Md.</i>				

MEDICAL CERTIFICATION

Examinee must be notified of once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, copies should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		8016543		REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) WILBUR PERRY DAWSON			2a. DATE OF DEATH JULY 13, 1980			2b. HOUR 11:45AM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH March 10, 1910		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS		7. IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Va.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY, MD.			
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Potomac State College	
13a. STATE W. Va.		13b. COUNTY Mineral		13c. CITY OR TOWN Keyser		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 230 Armstrong St.	
14. FATHER'S NAME FIRST MIDDLE LAST Thomas Dawson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nora Iser						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW 11		17. INFORMANT Louise Dawson		ADDRESS 230 Armstrong St. Keyser, W. Va.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>1629</u> <u>Drug mic coma.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic ca of the lung</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic Lymphocytic leukemia</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>7-10</u> 19 <u>80</u> , to <u>7-14</u> 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>7-17</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>John N. Mehanna</u>				DEGREE M.D.		22c. DATE SIGNED 7-14-80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN N. MEHANNA, M.D.				22e. ADDRESS 909-B SETON DRIVE, CUMBERLAND, MD. 21502					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 16 July 80		23c. NAME OF CEMETERY OR CREMATORY Potomac Mem. Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Keyser, Mineral W. Va.			
24. FUNERAL DIRECTOR NAME Allen ROTRUCK		ADDRESS 85 SOUTH MAIN STREET KEYSER, W. VA.		DATE REC'D. BY REGISTRAR JUL 18 1980		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

BP



WILKINSON FERRY LONDON JULY 12, 1980 11:45AM

1500  
 230 Armstrong St.  
 National  
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 ALLERANY COUNTY

JOHN A. MERRILL, INC.  
 600-E 1ST DRIVE, CLARKSBURG, MD. 21502  
 1500  
 230 Armstrong St.  
 National  
 ALLERANY COUNTY  
 1500  
 230 Armstrong St.  
 National  
 ALLERANY COUNTY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		8 0 1 6 5 4 4		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BESSIE R. DECKER		2a. DATE OF DEATH MONTH DAY YEAR JULY 21, 1980		2b. HOUR 6:30P M			
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 3 21 1912		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) TWIGG TOWN, MD	7b. CITIZEN OF WHAT COUNTRY? U S A	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY MD			
10. CITY OR TOWN OF DEATH CUMBERLAND	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RET, PASTRY COOK		12b. KIND OF BUSINESS OR INDUSTRY RESTAURANT		
13a. STATE MARYLAND		13b. COUNTY ALLEGANY	13c. CITY OR TOWN CUMBERLAND	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 115 N. WALNUT PLACE, CUMB, MD		
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM B. ROBINETTE		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FLORA MAE REED					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 217-10-1192		17. INFORMANT ADDRESS RUTH A. DANNER, CUMBERLAND, MARYLAND			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> 410- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardiogenic shock</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>MI</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u> <u>3 days</u> <u>6 days</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>repeated MI 2 days prior to death</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <u>7/18</u> , 19 <u>80</u> , to <u>7/21</u> , 19 <u>80</u> , that (1) (we) last saw the deceased alive on <u>7/18</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) did (did not) view the body after death.							
22b. SIGNATURE <u>AB Bollino</u>		DEGREE <u>MD</u>		22c. DATE SIGNED <u>25 July 80</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. ANTHONY J. BOLLINO, JR.		22e. ADDRESS MEMORIAL MEDICAL BLDG. CUMBERLAND, MD. 21502					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 7-24-1980		23c. NAME OF CEMETERY OR CREMATORY GREEN MEADOW CEMETERY			
24. FUNERAL DIRECTOR NAME LEASURE-STEIN FUNERAL HOME, INC. CUMB, MD.		23d. LOCATION CITY OR TOWN COUNTY STATE FLINSTONE ALLEGANY MARYLAND		25a. DATE REC'D. BY REGISTRAR AUG 04 1980			
25b. REGISTRAR'S SIGNATURE <u>Robert Kelly</u>							

6:30P

JULY 31, 1980

DECKER

P.

DESSIE

MEMORIAL HOSPITAL

CUMBERLAND

MEMORIAL MEDICAL BLDG.  
CUMBERLAND, MD. 21503

DR. ANTHONY J. POLLINO, JR.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8016545			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) ANNA BOYD DIEHL			2a. DATE OF DEATH JULY 20, 1980		2b. HOUR 1:22 PM		
3 SEX Female	4 RACE White	5 DATE OF BIRTH JULY 4, 1895	6 AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.				
10 CITY OR TOWN OF DEATH CUMBERLAND	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife,		12b. KIND OF BUSINESS OR INDUSTRY Own Home,		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland 13b COUNTY Allegany 13c CITY OR TOWN Cumberland,			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 806 Gephart Dr.		
14 FATHER'S NAME Joseph		15. MOTHER'S MAIDEN NAME Susan		16. ADDRESS Cumberland, Md.			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No,		16b SOCIAL SECURITY NO. 220-46-4644		17 INFORMANT Mrs. Susan D. Scott, 808 Gephart Dr. 21502			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malignant small cell Carcinoma, Stomach DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) 1519 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from 7-20 19 80, to 7-24 19 80, that (I) (we) lost saw the deceased alive on 7-20 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE Robustiano J. Barrera		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 7-25-80	
22d PHYSICIAN'S NAME (TYPE OR PRINT) XXXXXXXXXXXXXXXXXXXX DR. ROBUSTIANO BARRERA		22e ADDRESS MEMORIAL HOSPITAL MEDICAL BLDG. CUMBERLAND, MARYLAND 21502					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 7/22/80	23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland, Allegany Maryland			
24 FUNERAL DIRECTOR H. Wayne George 202 Greene St. Cumberland, Md.		25. DATE REC'D. BY REGISTRAR JUL 28 1980		25b. REGISTRAR'S SIGNATURE [Signature]			

ANNA MAY DIENT JULY 20, 1980 1:22P

CUMBERLAND MEMORIAL HOSPITAL

XXXXXXXXXXXXX DR. ROBERTO CUMBERLAND, MARYLAND 21202  
BARBARA

JUL 28 1980

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 1 6 5 4 6			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>MILTON H. DIGGINS</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>JULY 19, 1980</b>			
3 SEX <b>MALE</b>				2b. HOUR <b>1:27 PM</b>			
4 RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9 6 1913</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>66</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>WASHINGTON D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ALLEGANY</b> MD.	
10. CITY OR TOWN OF DEATH <b>CUMBERLAND, MD.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MEMORIAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RET. CHESSIE WKR</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>RAILROAD</b>	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>ALLEGANY</b>		13c. CITY OR TOWN <b>CUMBERLAND</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS <b>218 CARROLL STREET, CUMB, MD</b>		14. FATHER'S NAME FIRST MIDDLE LAST <b>COURTNEY DIGGINS</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>BEATRICE JOHNSON</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) <b>214-05-5281</b>		17. INFORMANT ADDRESS <b>NELLIE F. DIGGINS, CUMBERLAND, MD. 21502</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intractable Shock.</b> <b>44/4</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Retrosponded Bleeding, Cardiac &amp; Renal Failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Rupture of Abdominal Aortic Aneurysm.</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 days.</b> <b>3 days.</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION <b>July 16, 1980.</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Abdominal Aortic Aneurysm -</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to <b>July 19</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>July 19</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Calvin Y. Hadidian</b>				DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>7/24/80.</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. CALVIN Y. HADIDIAN</b>				22e. ADDRESS <b>MEMORIAL MEDICAL BUILDING CUMBERLAND, MD. 21502</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>7-22-1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>WOODLAWN CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>CUMBERLAND ALLEGANY MD</b>	
24. FUNERAL DIRECTOR NAME <b>LEASURE-STEIN FUNERAL HOME, INC. CUMB, MD.</b>				25a. DATE REC'D. BY REGISTRAR <b>JUL 30 1980</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

1:27P

JULY 12, 1980

MILTON H. DIGGINS

MEMORIAL

CUMBERLAND, MD.

MEMORIAL MEDICAL BUILDING  
CUMBERLAND, MD. 21502

DR. CALVIN Y. HABIDIAN

MIL 30 KRM



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 25M  
(VRA 15, 4) 1/79

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		8016547		REG. NO.					
1 DECEASED NAME (TYPE OR PRINT) MINNIE O. DIGMAN				2a DATE OF DEATH MONTH DAY YEAR JULY 26, 1980		2b HOUR 1:50P M			
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Dec. 7, 1888		6 AGE (IN YEARS LAST BIRTHDAY) 91 YRS.		7 UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.			
10 CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b KIND OF BUSINESS OR INDUSTRY Own Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a STATE Md.		13b COUNTY Allegany		13c CITY OR TOWN Cumberland		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14 FATHER'S NAME FIRST MIDDLE LAST Martin Ice				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Zora B. Ridgeway					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17 INFORMANT ADDRESS Mr. George M. Digman, Cumberland, Md. Son					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Cardio respiratory failure</i>									
410 - DUE TO, OR AS A CONSEQUENCE OF (b) <i>Myocardial Infarction</i>									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <i>George M. Digman</i>				DEGREE				22c DATE SIGNED	
22d PHYSICIAN'S NAME (TYPE OR PRINT) DR. ROBERT J. BARRERA				22e ADDRESS MEMORIAL HOSPITAL MED. BLDG. CUMBERLAND, MARYLAND 21502					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 7-29-1980		23c NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d LOCATION CITY OR TOWN COUNTY STATE Cumberland, Allegany, Md.			
24 FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, Md.				25a DATE REC'D. BY REGISTRAR AUG 04 1980		25b REGISTRAR'S SIGNATURE <i>Peter McQuay</i>			

MINNIE O. BIRMAN JULY 26, 1920 1:20P

Female white Dec. 7, 1928

CUMBERLAND MEMORIAL HOSPITAL  
Albany, Cumberland  
Cumberland, Md.

Id. Albany, Cumberland  
Cumberland, Md.

Id. Albany, Cumberland  
Cumberland, Md.

Id. Albany, Cumberland  
Cumberland, Md.

Id. Albany, Cumberland  
Cumberland, Md.

Id. Albany, Cumberland  
Cumberland, Md.

Id. Albany, Cumberland  
Cumberland, Md.

Id. Albany, Cumberland  
Cumberland, Md.

Id. Albany, Cumberland  
Cumberland, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO.		8 0 1 6 5 4 8					
1. DECEASED NAME (TYPE OR PRINT)			2. DATE OF DEATH			3. HOUR			4. MIN
DONALD LAWRENCE ELLSWORTH			JULY 23, 1980			6:25P			M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Male		White		Sept. 22, 1932		47 YRS		MONTHS DAYS HOURS MIN	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		9. CITIZEN OF WHAT COUNTRY?		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		USA				ALLEGANY COUNTY, MD.			
12. CITY OR TOWN OF DEATH		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		15. KIND OF BUSINESS OR INDUSTRY	
Cumberland		SACRED HEART HOSPITAL				Production Dept.		Bakery	
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			17. INSIDE CITY LIMITS?			18. STREET ADDRESS			
13a. STATE 13b. COUNTY 13c. CITY OR TOWN Md. Allegany La Vale			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			220 S. First St.			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME					
Lawrence E. Ellsworth				Mary A. Shroyer					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
yes				Korean		Mrs. Mary Louise Ellsworth, La Vale, Md. Wife			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Metastatic liver coma.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>late stage adenocarcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>of the colon</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>7-20</u> 19 <u>80</u> to <u>7-23</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>7-23</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>John N. Mehan</u>						DEGREE M.D.		22c. DATE SIGNED 7-24-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN N. MEHANNA, M.D.						22e. ADDRESS 909-B SETON DRIVE, CUMBERLAND, MD. 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial			7-26-1980		Restlawn Mem. Gardens		La Vale, Allegany, Md.		
24. FUNERAL DIRECTOR NAME			25. DATE REC'D BY REGISTRAR			26. REGISTRAR'S SIGNATURE			
SCARPELLI (James F.)			108 VIRGINIA AVE. CUMBERLAND, MD. 21502			JUL 28 1980			

JULY 27, 1960 7:25P

LAWRENCE LILLWORTH DONALD

White 45 Maryland

SACRED HEART HOSPITAL 200 N. Tenth St. Baltimore

Lawrence L. Lillworth

212 - 2125 - 1234

212 - 2125 - 1234

212 - 2125 - 1234

200 N. Tenth St. Baltimore, MD. 21202

212 - 2125 - 1234  
212 - 2125 - 1234  
212 - 2125 - 1234

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17  
(VR A15 ME (5))  
15M 7/77

FOR 1- STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										70116549 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Walter W Ensminger										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 7-15-80										2b. HOUR 1p M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 10 1905		6. AGE (IN YEARS) LAST BIRTHDAY 75 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 7-15-80										2d. HOUR 2p M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD											
10. CITY OR TOWN OF DEATH Cumberland				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 221 Emily Street								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Employee				12b. KIND OF BUSINESS OR INDUSTRY Textile							
13a. STATE Maryland				13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 221 Emily Street													
14. FATHER'S NAME FIRST MIDDLE LAST William Isaac Ensminger										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nellie Lindsay													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) , No				16b. SOCIAL SECURITY NO. 214-07-3029		17. INFORMANT Mrs. Susan D. Ensminger				ADDRESS 221 Emily Street Cumberland, Md													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 9520 IMMEDIATE CAUSE (a) Asphyxiation DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Carbon Monoxide Poisoning DUE TO, OR AS A CONSEQUENCE OF (c) (Suicide - auto exhaust in garage										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes " "													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Car															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																							
ACTUAL SIGNATURE Benedict Skitarelic				TITLE (SPECIFY) M.D. Deputy				MEDICAL EXAMINER				DATE SIGNED 7-15-80											
EXAMINER'S NAME (TYPE OR PRINT) Benedict Skitarelic, M.D.				ADDRESS R#9, Cumberland, Maryland 21502																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE July 18/80		23c. NAME OF CEMETERY OR CREMATORY S.S. Peter & Paul Cem				23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany Maryland													
24. FUNERAL DIRECTOR NAME Silcox--Merritt,				ADDRESS Cumberland, Maryland 21502				25a. DATE REC'D. BY REGISTRAR JUL 18 1980				25b. REGISTRAR'S SIGNATURE [Signature]											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the hospital or funeral director must be notified.

FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		8 0 1 6 5 5 0		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>GIUSEPPE G. FEMIA</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>JULY 30, 1980</b>		2b. HOUR <b>12:47<sup>A</sup></b>			
3 SEX <b>Male</b>	4 RACE <b>White</b>	5 DATE OF BIRTH MONTH DAY YEAR <b>Oct. 22, 1897</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Italy</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD.			
10 CITY OR TOWN OF DEATH <b>CUMBERLAND</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MEMORIAL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Restaurant Oper.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>		
13a. STATE <b>W.Va</b>		13b. COUNTY <b>Mineral</b>	13c. CITY OR TOWN <b>Keyser</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>71 Maple Avenue</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Salvador ----- Femia</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Cattina -----</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			
16b. SOCIAL SECURITY NO. <b>705-12-4714</b>		17 INFORMANT ADDRESS <b>Mrs. Theresa Femia, 71 Maple Ave. Keyser, W.Va.</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arterio myocardial infarction</b> <b>410-</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Cerebrovascular disease</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>7/2</b> , 19 <b>80</b> , to <b>7/30</b> , 19 <b>80</b> , that (I) (we) lost saw the deceased alive on <b>7/29</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Peter Halmos</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>7/30/80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. PETER HALMOS</b>		22e. ADDRESS <b>MEMORIAL HOSPITAL CUMBERLAND, MD. 21502</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>8-1-80</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Thomas Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Keyser Mineral W.Va.</b>			
24. FUNERAL DIRECTOR <b>W. neef</b>		24b. ADDRESS <b>Keyser, W.Va.</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 04 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Tracy McBratney</b>	



12:44 JUL 30 1980

100-12-114

CUMBERLAND MEMORIAL HOSPITAL

100-12-114

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 833-3333.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8016551			
FOR 1- STATE REGISTRAR		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2r. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
LUTHER		WEBSTER		FINK		JULY 15, 1980		12:20AM					
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male		White		MONTH DAY YEAR March 4, 1907		73 YRS		MONTHS DAYS		HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH							
Virginia		U.S.				ALLEGANY COUNTY, MD.							
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Cumberland		SACRED HEART HOSPITAL		Machine Operator		Celanese Corp.							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
WV		Mineral		Ridgeley		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rt. 2, Box 448					
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME											
FIRST MIDDLE LAST		FIRST MIDDLE LAST											
Lorenzo F.		Elizabeth											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO		17 INFORMANT		ADDRESS							
YES		WWII		218-12-5704A		Glenwood Fink;		Rt. 2, Box 448, Ridgeley, WV 26753					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Septic shock</u> 1561 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Ca common bile duct</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>5 mos</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 mos</u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>W. B. Flores</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
DR. A. B. FLORES		924 SETON DRIVE, CUMBERLAND, MD. 21502											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE							
Burial		July 18, 1980		Springfield Hill		Springfield, Hamp. WV							
24 FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
SHAFFER FUNERAL HOME, ROMNEY, WVA.		JUL 23 1980		Keith S. Shaffer									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 0 1 6 5 5 2				
1. FOR STATE REGISTRAR					REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) <b>GENE FIVE</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>JULY 30, 1980</b>					2b. HOUR <b>11:20 AM</b>				
3 SEX <b>Female</b>					4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>7 28 1980</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>88</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>					7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ALLEGANY COUNTY, MD.</b>					
10 CITY OR TOWN OF DEATH <b>Cumberland</b>					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SACRED HEART HOSPITAL</b>					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Nurse</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Hospital</b>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13a. STATE <b>Md.</b>		13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Westernport</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>Kolberg Hill Westernport Md.</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>George Fisher</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Wilhelmina Nehring</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>					16b. SOCIAL SECURITY NO. <b>579-44-7516</b>		17 INFORMANT ADDRESS <b>Mrs Nelda Ferguson Westernport Md.</b>							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac failure</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
4292 DUE TO, OR AS A CONSEQUENCE OF (b) <b>CZ bleeding undetermined origin</b>														
DUE TO, OR AS A CONSEQUENCE OF (c) <b>ASCVD, Organic Brain Syndrome</b>														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)														
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>July 29, 19 80</b> to <b>July 30, 19 80</b> , that (I) (we) lost the deceased alive on <b>July 30, 19 80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do) not view the body after death.														
22b. SIGNATURE <b>Shin Eung Kim</b> DEGREE <b>MD</b>										22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SHIN EUNG KIM, M.D.</b>					22e. ADDRESS <b>90 MAIN STREET, WESTERNPORT, MD. 21539</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>					23b. DATE <b>8/2/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Peters Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY <b>Westernport Allegany Md.</b>					
24 FUNERAL DIRECTOR NAME <b>BOAL'S</b>					24b. ADDRESS <b>Funeral Service</b>		25. DATE REC'D. BY REGISTRAR <b>AUG 04 1980</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>					

2 JUL 20 1980 11:20A

ALLIANCE COUNTY  
SACRED HEART HOSPITAL  
CATHOLIC CHURCH

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CATHOLIC CHURCH

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
15M7/77

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
DECEASED NAME (TYPE OR PRINT)		DATE KNOWN OF DEATH		DATE OF DEATH	
Jason D Flanagan		7-26-80		1:20a	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.
Male	White	3-3-62	18 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED	NEVER MARRIED	9. BALTIMORE CITY OR COUNTY OF DEATH	
	USA			Allegany MD.	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Cumberland	XXXXXXXX DOA Memorial Hospital	Student-Graduate		High School	
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
W.Va.	Mineral	Keyser	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	Rt. #2	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			
Gerald L. Flanagan	Betty L. Hull	no			
16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
		Mr. Gerald L. Flanagan, Keyser, W.Va. Father			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Crushed Skull; Fractured Neck					
DUE TO, OR AS A CONSEQUENCE OF					
(b) (One car accident)					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
		12:40 AM 7-26-80		Driver in single car accident	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION	
		Rt. #28, One mile south of Ridgeley, Mineral, West Virginia			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED	
Benedict Skitarelic		Deputy		7-26-80	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS			
Benedict Skitarelic, m.d.		R#9, Cumberland, Maryland 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Burial	July 28, 1980	Fort Ashby Cemetery		Fort Ashby W. Va.	
24. FUNERAL DIRECTOR		25a. DATE RECEIVED BY		25b. SIGNATURE	
James F. Scarpelli		AUG 1 1980			

Student-Exchange Program

Exchange of Students

Program

July 1, 1968

Exchange of Students

Mr. James A. Flanagan, Director, U.S. Education

to

July 2, 1968  
U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C.

Enclosed

1. Exchange of Students

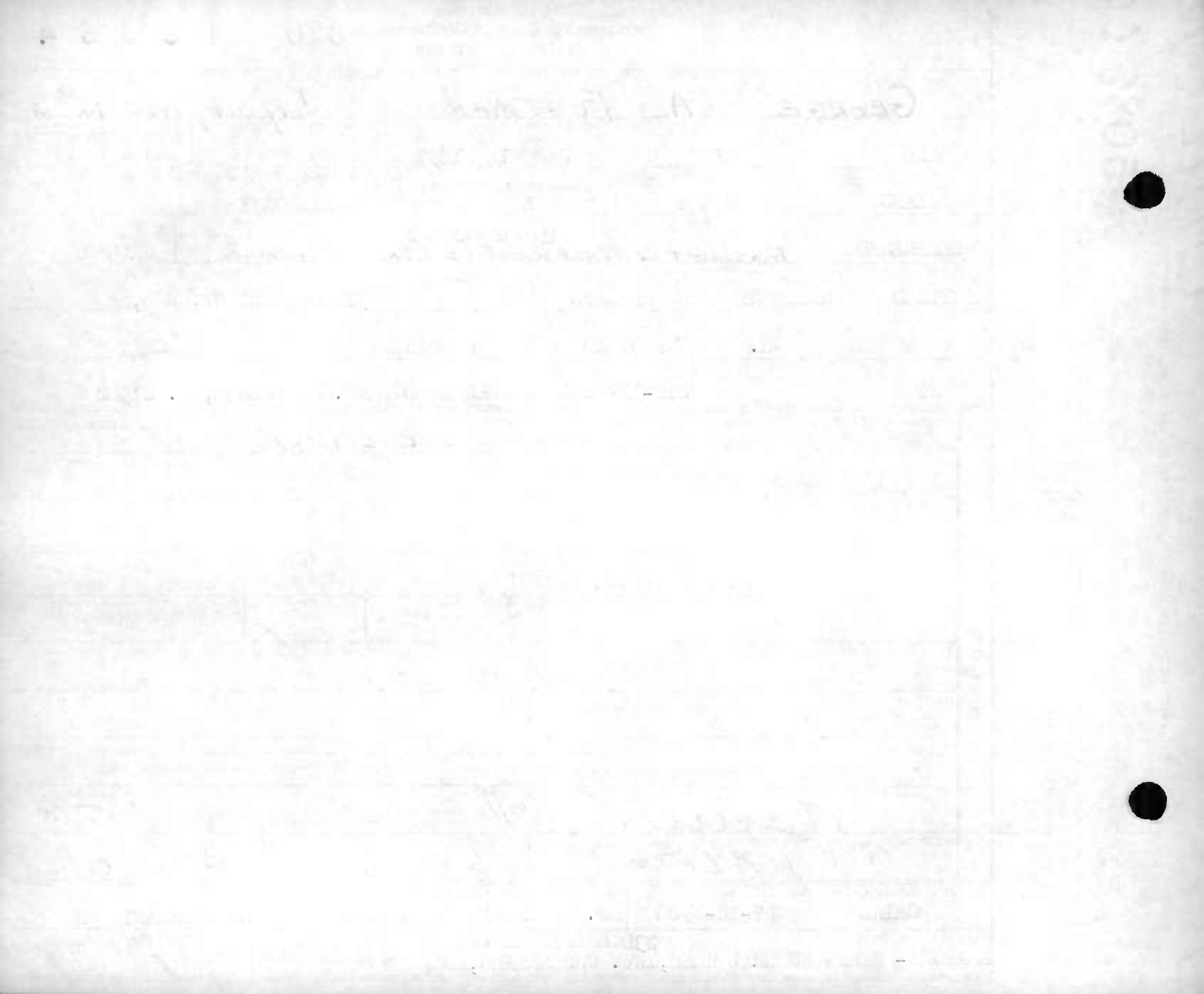
Program



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

1. FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		8 0 1 6 5 5 4 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>GEORGE A. FOGTMAN</b>		2a. DATE OF DEATH <b>July 16, 1980</b>		2b. HOUR <b>12:50 A.M.</b>	
3. SEX <b>MALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>JAN 14 1891</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>89</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOW <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ALLEGANY</b> MD.	
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NURSING + CONVALESCENT CENTER</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RET. GROCER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>GROCERY</b>
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>ALLEGANY</b>	13c. CITY OR TOWN <b>CUMBERLAND</b>	13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>AUGUST H. FOGTMAN</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARGARET BROCKEY</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>212-32-8208</b>		17. INFORMANT ADDRESS <b>ESTHER I FOGTMAN, CUMBERLAND, MD. 21502</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral aneurysm, dissecting.</b> <b>4379</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>General debility.</b>					
19a. DATE OF OPERATION <b>7-18-1980</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Halim</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>7/17/80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>P. B. HAZARD</b>		22e. ADDRESS <b>303 S. Schley St. Cumberland</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>7-18-1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>SS. PETER &amp; PAUL CEMETERY</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>CUMBERLAND ALLEGANY MD</b>		23e. DATE REC'D. BY REGISTRAR <b>JUL 22 1980</b>			
24. FUNERAL DIRECTOR NAME <b>LEASURE - STEIN FUNERAL HOME, INC.</b>		230. BALTIMORE AVE ADDRESS <b>CUMBERLAND, MD</b>		25a. DATE REC'D. BY REGISTRAR <b>JUL 22 1980</b>	
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
1. FOR STATE REGISTRAR		2r. DATE OF DEATH				MONTH		DAY		YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		JULY		24		9:15P M	
2. SEX		3. RACE		4. DATE OF BIRTH		5. AGE (IN YEARS LAST BIRTHDAY)		6. IF UNDER 1 YEAR		7. IF UNDER 24 HRS		8. MONTHS	
Male		White		4-25-1899		81		YRS		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Md		U.S.A.				ALLEGANY COUNTY, MD							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Cumberland		SACRED HEART HOSPITAL		Retired Miner									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
Md		Allegany		Lonaconing		YES <input type="checkbox"/> NO <input type="checkbox"/>		23 Watercliffe Street					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
Felix		Sally		Ann Wright									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
no				Mrs. Grace Foote		Lonaconing, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Pneumonia</u>												10 days	
496- CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.												years	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>COPD</u>													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):													
ACVD													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
		HOUR A.M. MONTH DAY YEAR											
		P.M. 19											
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION									
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		[AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.]		STREET		CITY OR TOWN COUNTY STATE							
22. I certify that (I) (this hospital) attended the deceased from 19-57 to July 24, 19-80, that (I) (we) last saw the deceased alive on July 24, 19-80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED							
Leslie Miles, M.D.		MD				7-25-80							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
LESLIE MILES, M.D.		55 JACKSON STREET, LONACONING, MD. 21539											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. COUNTY					
Burial		7/26/80		Oak Hill Cemetery		Lonaconing		A. MS					
24. FUNERAL DIRECTOR		24a. NAME		24b. ADDRESS		24c. DATE REC'D. BY REGISTRAR		24d. REGISTRAR'S SIGNATURE					
EICHORN		Funeral Home		8 MAIN STREET, LONACONING, MD. 21539		JUL 29 1980		P. J. McCreedy					



JULY 21, 1980

POINT

THEATRE

LESLIE

81

1 - 21 - 1980

White

Male

ALLEGANY COUNTY

SANDED HEART HOSPITAL

CHURCH ST

NO

Female

Female

Female

Female

Female

NO

10 days

1 year

Poliovirus  
C90D

ACVD

08 25 July 80

08 25 July 80

08-25-80

X

Dr. J. M. M. M.

22 JACKSON STREET, LAMONING, MD. 21530

LESLIE MILES, M.D.

ONE 1111 JACKSON ST. LAMONING, MD. 21530

HICKORY STREET HOME LAMONING, MD. 21530



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 25M  
(VRA 15, 4) 1/79

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		8 0 1 6 5 5 6		REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) NELLIE MARIE GARLITZ				2a. DATE OF DEATH MONTH DAY YEAR JULY 8, 1980		2b. HOUR 8:30 A.M.			
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 30, 1906		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY, MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Penna 13b. COUNTY Somerset 13c. CITY OR TOWN Boynton				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Boynton, Pa.			
14. FATHER'S NAME FIRST MIDDLE LAST Sylvester Hemming				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sadie Dayton					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 174-16-2542		17. INFORMANT ADDRESS B. A. Ernest Garlitz, Boynton Pa.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> 4280 DUE TO, OR AS A CONSEQUENCE OF (b) <u>C.H.F. &amp; other J.B.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>7-6</u> , 19 <u>80</u> , to <u>7-8</u> , 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>7-8</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Uriel Velandia</u>				DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) URIEL VELANDIA, M.D.				22e. ADDRESS 924 SETON DRIVE, CUMBERLAND, MD. 21502					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE July 11, 80		23c. NAME OF CEMETERY OR CREMATORY Salisbury Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury Somerset Pa			
24. FUNERAL DIRECTOR NAME J. J. THOMAS				25a. DATE OF DED. BY REGISTRAR JUL 13 1980		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

514-175

2261

UNITED STATES

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 1 6 5 5 7 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST AGNES NMI GEORGE				2a. DATE OF DEATH MONTH DAY YEAR JULY 31, 1980				2b. HOUR 6:50 P.M.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 3 21 1905		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY, MD.					
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic		12b. KIND OF BUSINESS OR INDUSTRY housework			
13a. STATE Maryland				13b. COUNTY Allegany		13c. CITY OR TOWN Barton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Barton, Maryland	
14. FATHER'S NAME FIRST MIDDLE LAST William E. George				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Janet Powers							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO. 214-74-6075		17. INFORMANT ADDRESS Martha Kirk Barton Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4292 Congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCD &amp; At. fib.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>years</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>days</u>	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>Diabetes: CA of Colon</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>7/28/80</u> to <u>7/31/80</u> , that (I) (we) <input checked="" type="checkbox"/> saw the deceased alive on <u>7/31/80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>N. Columbia M.D.</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>8/4/80</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>R. ESPINA MD</u>				22e. ADDRESS <u>907 SETON DR. Cumh.</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 8/3/1980		23c. NAME OF CEMETERY OR CREMATORY Laurel Hill		23d. LOCATION CITY OR TOWN COUNTY STATE Barton Allegany Md.			
24. FUNERAL DIRECTOR NAME <u>Boal's Funeral Home</u>				24b. CHURCH STREET WESTERNPORT, MD.				24c. DATE REC'D. BY REGISTRAR 21562 1 1980		24d. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



10521

JULY 21, 1950 8:20 P

STATION

NAME



ALLIANCE COUNTY

SACRED HEART HOSPITAL

Constitution West Fairview  
AZOV 2 AF file

Birth: CA of color

5/21 80 5/21 80 5/21 80

R. EZZINA, MD  
205 SETON DR. CUMH.  
8/1/80

ALICE (RND)

BOAL'S PLANT HONE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8016558			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>HELEN THERESA GOLDSWORTHY</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>JULY 27, 1980</b>			
3 SEX <b>Female</b>				2b. HOUR <b>8:50 P.M.</b>			
4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Nov. 10, 1904</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>75</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ALLEGANY COUNTY, MD.</b>			
10 CITY OR TOWN OF DEATH <b>Cumberland</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>SACRED HEART HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Allegany</b> 13c. CITY OR TOWN <b>LaVale</b>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>6 Camp Ground Rd.</b>	
14 FATHER'S NAME FIRST <b>Richard</b> MIDDLE <b>--</b> LAST <b>Pugh</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Sarah</b> MIDDLE <b>--</b> LAST <b>Freal</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO.		17 INFORMANT ADDRESS <b>Cumberland, Md.</b> <b>Mr. Paul R. Goldsworthy, 412 Fayette St. 21502</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Renal Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic nephropathy</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Chronic Rheumatoid arthritis</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>many months</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Cardio megal, hypohaline, hypothyroidism</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>4/29/80</b> to <b>7/27/80</b> , that (I) (we) lost saw the deceased alive on <b>7/2/80</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>S. Sandhir MD</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>7/28/80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. S. SANDHIR</b>				22e. ADDRESS <b>48 TARN TERRACE, FROSTBURG, MD. 21532</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7/30/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery, Cumberland, Allegany Maryland</b>		23d. LOCATION CITY OR TOWN COUNTY STATE	
24 FUNERAL DIRECTOR NAME <b>H. Wayne George</b> ADDRESS <b>21502</b>				25a. DATE REC'D. BY REGISTRAR <b>AUG 1 1980</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	
26. FUNERAL HOME, 202 GREENE ST., CUMBERLAND, MD.							

BP

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LIBRARY COUNTY

147792-92 T9A72 058012

\$17.95 (2.00)

2116

(152)

GEORGE FUNDAL HOME 303 6TH ST.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8016559			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) EARL E. GREW SR.				2. DATE OF DEATH MONTH DAY YEAR JULY 14 1980			
3. SEX Male				2b. HOUR 5:55 PM			
4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 24 1910		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY, MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Barber		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Pa.				13b. COUNTY Somerset		13c. CITY OR TOWN	
14. FATHER'S NAME FIRST MIDDLE LAST Austin Grew				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Plitt			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 170-18-2234		17. INFORMANT ADDRESS Effie S. Grew RDL Meyersdale, Pa.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic disease of lung</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>lung</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Urinary bladder CA</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1629</u> months							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from <u>6/23/80</u> , to <u>7/14/80</u> , that (I) (we) saw the deceased alive on <u>7/14/80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Renato Espina, M.D.</u>		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>7/15/80</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RENATO ESPINA, M.D.		22e. ADDRESS 907 SETON DRIVE, CUMBERLAND, MD 21502					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/17/80		23c. NAME OF CEMETERY OR CREMATORY Lichty		23d. LOCATION CITY OR TOWN COUNTY STATE RDL Meyersdale, Pa.	
24. FUNERAL DIRECTOR NAME LECKENBY		ADDRESS CORPUS FUNERAL HOME, MEYERSDALE, PA		25a. DATE REC'D. BY REGISTRAR JUL 14 1980		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

$\frac{0}{2} \frac{2}{2} \frac{5}{5} \frac{1}{1} \frac{5}{5}$        $\frac{2}{2} \frac{5}{5} \frac{2}{2} \frac{1}{1} \frac{5}{5}$   
 $\frac{2}{2} \frac{2}{2} \frac{5}{5}$        $\frac{2}{2} \frac{5}{5} \frac{2}{2} \frac{1}{1} \frac{5}{5}$

1. NAME \_\_\_\_\_

BP

DHMH - 17  
(VR A15 ME (5))  
15M 7/76

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, IT MUST BE EXECUTED WITHIN 72 HOURS AFTER DEATH. THE WORD "PENDING" IN PENCIL IN ITEM 1B, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 8016560			
1. FOR STATE REGISTRAR		2a. DECEASED NAME (TYPE OR PRINT) <b>Chester Madison Guthrie</b>						2b. DATE KNOWN OF DEATH <b>XX</b> MONTH <b>XX</b> DAY <b>1</b> YEAR <b>1980</b>		7b. HOUR <b>8:50 A.M.</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>Dec.</b> DAY <b>20</b> YEAR <b>1915</b>		6. AGE IN YEARS (LAST BIRTHDAY) <b>64</b> YRS.		IF UNDER 1 YR. MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>W. Va.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD.				2c. DATE PRONOUNCED DEAD <b>July 1, 1980</b> 7d. HOUR <b>8:50 A.M.</b>			
10. CITY OR TOWN OF DEATH <b>Cumberland,</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>D. O. A. Memorial Hosp.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ret. Conductor</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Railroad,</b>					
13a. STATE <b>W. Va.</b>		13b. COUNTY <b>Mineral</b>		13c. CITY OR TOWN <b>Ridgeley,</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>18 Potomac St.</b>					
14. FATHER'S NAME (FIRST, MIDDLE, LAST) <b>Clinton -- Guthrie</b>		15. MOTHER'S MAIDEN NAME (FIRST, MIDDLE, LAST) <b>Bessie -- Seymour</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No,</b>				16b. SOCIAL SECURITY NO. <b>232-22-1684</b>		17. INFORMANT ADDRESS <b>Ridgeley, W. Va. Mrs. Jennie J. Guthrie, 18 Potomac St.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>1629</b> IMMEDIATE CAUSE (a) <b>CARCINOMATOSIS, GENERALIZED</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>CARCINOMA OF RT. LUNG,</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>MOS.</b> <b>1 YR.</b>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>				TITLE (SPECIFY) <b>Deputy,</b> M.D.				MEDICAL EXAMINER				DATE SIGNED <b>7/1/80</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>Benedict Skitarelic, M. D.</b>				ADDRESS <b>Rt. # 9 Cumberland, Md. 21502</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>7/5/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bayard Cemetery</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Bayard, Grant Co. W. Va.</b>			
24. FUNERAL DIRECTOR NAME <b>H. Wayne George</b>				ADDRESS <b>202 Greene St. Cumberland, Md. 21502</b>				25a. DATE REC'D. BY REGISTRAR <b>JUL 7 1980</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			



1954



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17  
(VR A15 ME (5))  
15M7/77

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME  
(TYPE OR PRINT)

ANNIE

FIRST

MIDDLE

LAST

HALL

2a. DATE KNOWN  
OF  
DEATH2b. DATE KNOWN  
OF  
DEATH

July 24, 1980

2c. HOUR  
P M

P M

3. SEX

Female

4. RACE

White

5. DATE OF BIRTH,  
MONTH DAY YEAR

Feb. 12, 1903

6. AGE (IN YEARS  
LAST BIRTHDAY)

77 YRS.

IF UNDER 1 YR.  
MONTHS DAYSIF UNDER 24 HRS.  
HOURS MIN.2c. DATE  
PRONOUNCED  
DEAD

July 28, 1980

2d. HOUR  
A M

A M

7a. BIRTHPLACE (STATE OR  
FOREIGN COUNTRY)

West Virginia

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☐ NEVER MARRIED ☐  
WIDOWED ☐ DIVORCED ☒

9. BALTIMORE CITY OR COUNTY OF DEATH

Allegany

MD.

10. CITY OR TOWN OF DEATH

Cumberland

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION  
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

Creek Road

12a. USUAL OCCUPATION (TYPE OF WORK  
FOR MOST OF WORKING LIFE)

Ret. Housekeeper, Pvt. Home

12b. KIND OF BUSINESS  
OR INDUSTRY

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. COUNTY

Allegany

13c. CITY OR TOWN

Cumberland

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS

Creek Road

14. FATHER'S NAME

FIRST

Arnold

MIDDLE

LAST

Hall

15. MOTHER'S MAIDEN NAME

FIRST

Lettei

MIDDLE

LAST

Goldizen

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(YES, NO, OR UNKNOWN)

No

16b. SOCIAL SECURITY NO.

Unknown

17. INFORMANT

ADDRESS

Zone Hall, Cumberland, Maryland

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1 DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

CORONARY OCCLUSION

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a) stating the under-  
lying cause last.

(b)

CORONARY SCLEROSIS

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

SUDDEN

-----

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

MEDICAL CERTIFICATION

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR  
CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐  
AT WORK AT WORK21e. PLACE OF INJURY (AT HOME,  
STREET, FACTORY, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opiniondeath resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL

SIGNATURE

Benedict Skitarelic

TITLE (SPECIFY)

M.D. Deputy

MEDICAL EXAMINER

DATE

SIGNED July 28, 80

EXAMINER'S NAME  
(TYPE OR PRINT)

BENEDICT SKITARELIC, M.D.

ADDRESS

Rt. 9, Cumberland, Maryland 21502

23a. BURIAL, CREMATION, REMOVAL  
(SPECIFY)

Burial

23b. DATE

July 30, 1980

23c. NAME OF CEMETERY OR CREMATORY

Hillcrest

23d. LOCATION  
CITY OR TOWN

Burial P

Cumberland Allegany, Md.

COUNTY

STATE

24. FUNERAL DIRECTOR

NAME William Knight

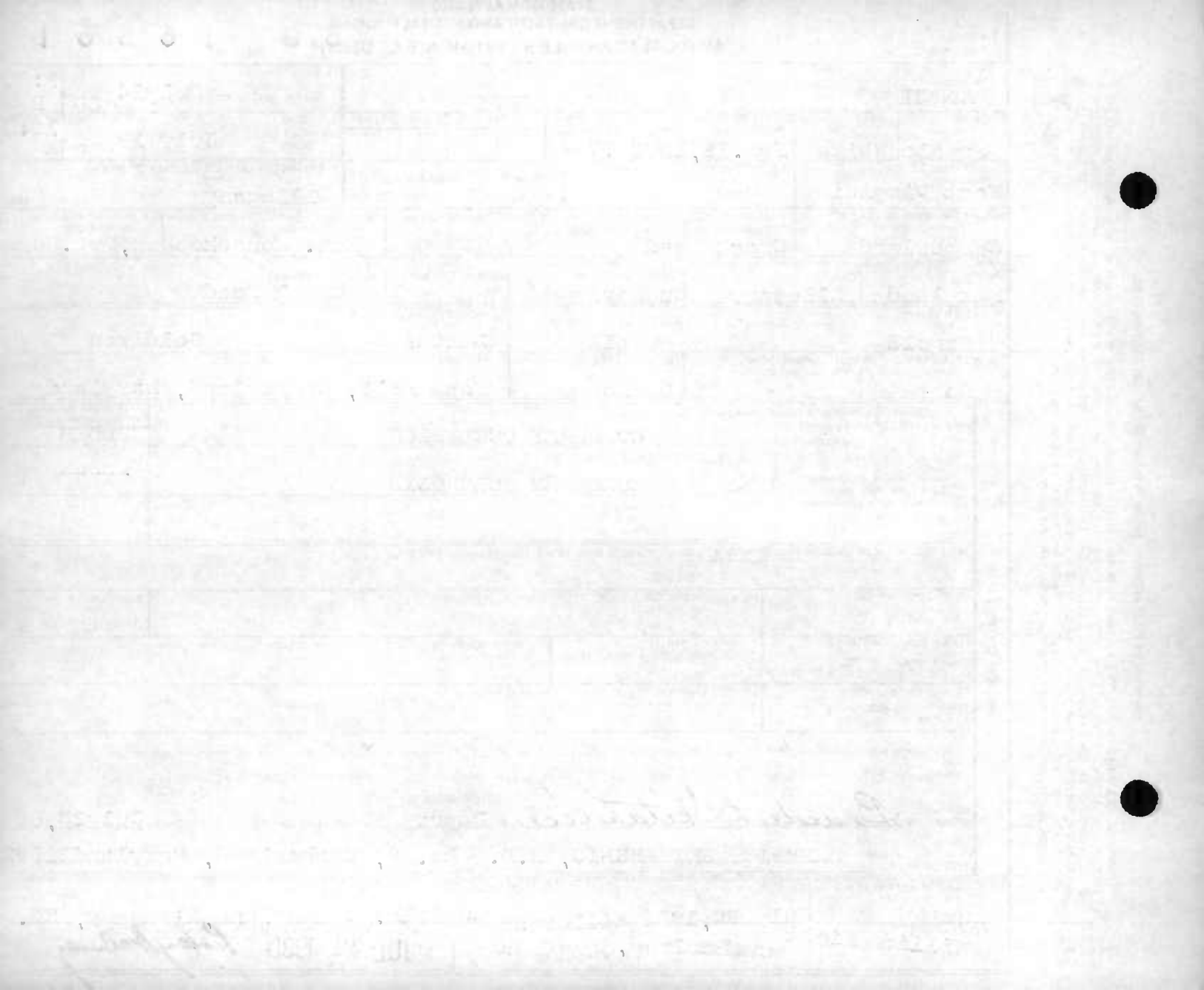
Cumberland, Maryland

25a. DATE REC'D. BY REGISTRAR

JUL 31 1980

25b. REGISTRAR'S SIGNATURE

Ruthy, Kennedy



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR 1 - STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		8 0 1 6 5 6 2		
1 DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a DATE OF DEATH MONTH DAY YEAR	2b HOUR
JAMIE DENISE HARTMAN					JULY 02, 1980	4:45 P.M.
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7 IF UNDER 1 YEAR
Female	White	MONTH DAY YEAR 7 2 80		YRS MONTHS DAYS		9 23
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH		
MARYLAND	U.S.A.			ALLEGANY CO., MD.		
10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
CUMBERLAND	MEMORIAL HOSPITAL					
13a STATE		13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET ADDRESS	
Md.	Allegany			YES <input type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME				
FIRST MIDDLE LAST James Dennis Hartman		FIRST MIDDLE LAST Kimbra Lee Tell				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS		
		None		James D. Hartman Md. Ave Westernport Md.		
18 CAUSE OF DEATH (Enter only one cause per line 1a, 1b, 1c, and 1d.) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7998 <u>CARDIO-RESPIRATORY FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>SEVERE PREMATUREITY.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ (d) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>NOT KNOWN</u>						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (I) (this hospital) attended the deceased from <u>7/2/80</u> to <u>7/2/80</u> , that (I) (we) last saw the deceased alive on <u>7/2/80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <u>7/9/80</u>
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS				
A. PATHAK, M.D.		913 SETON DR., CUMBERLAND, MD. 21502				
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE	23c NAME OF CEMETERY OR CREMATORY		23d LOCATION	
Burial		7/3/80	Philos		Westernport Md any stat.	
24 FUNERAL DIRECTOR NAME		25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE		
BOAL'S FUNERAL HOME		JUL 14 1980		P. K. Kelly		

JAMIE DENISE MARTIN JULY 03, 1980

WEST VIRGINIA 1 2 3

MARYLAND 112.1 ALLEGANY CO.

CUMBERLAND MEMORIAL HOSPITAL

AD. 112.1

112.1 112.1

112.1 112.1 112.1

CHINA BIRTH RECORD

CHINA BIRTH RECORD

NOT KNOWN

112.1 112.1 112.1

112.1 112.1

A. PATMAN, M.D. 112.1 112.1 112.1

112.1 112.1 112.1

BOAL'S FUNERAL HOME

BP

DHMH - 17  
(VR A15 ME (5))  
15M7/77

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 7016563			
1. DECEASED NAME (TYPE OR PRINT) <b>Carl Emil Herberger</b>										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> <b>7-1-80</b>		2b. HOUR <b>10:30p</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10-9-1893</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>86</b> YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD <b>7-1-80</b>		2d. HOUR <b>10:30p</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Wash., D.C.</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD			
10. CITY OR TOWN OF DEATH <b>Cumberland</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Sacred Heart Hospital---DOA</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ret. Plate Printer</b>				12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Pr. Geo.</b>		13c. CITY OR TOWN <b>Mt. Rainier</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>29th 4120 49th. Street.</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Otto T. Herberger</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna Bankman</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>220-44-1959</b>		17. INFORMANT ADDRESS <b>Same as Carl E. Herberger (Son) Above</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>410- IMMEDIATE CAUSE (a) CORONARY OCCLUSION</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. <b>(b) CORONARY SCLEROSIS</b> <b>(c)</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>SUDDEN</b>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>				TITLE (SPECIFY) <b>Deputy</b>				DATE SIGNED <b>7-1-80</b>					
EXAMINER'S NAME (TYPE OR PRINT) <b>BENEDICT SKITARELIC, M.D.</b>				ADDRESS <b>R#9, CUMBERLAND, MARYLAND XXXXX</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>7-5-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brentwood Pr. Geo. Md.</b>					
24. FUNERAL DIRECTOR NAME ADDRESS <b>Nalley's F.H. Inc. Mt. Rainier, Md.</b>						25a. DATE REC'D. BY REGISTRAR <b>JUL 7 1980</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	0	1	6	5	6	4		
1. FOR STATE REGISTRAR										REG. NO.								
1. DECEASED NAME (TYPE OR PRINT) <b>ALLexander m Jack</b>										2a. DATE OF DEATH MONTH DAY YEAR <b>July 29-80</b>							2b. HOUR <b>16:40 P.M.</b>	
3. SEX <b>Male</b>			4. RACE <b>White</b>			5. DATE OF BIRTH MONTH DAY YEAR <b>April 22, 1895</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b> YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD.									
10. CITY OR TOWN OF DEATH <b>Cumberland</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Cumberland Nursing Center</b>							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>					
13a. STATE <b>Md.</b>			13b. COUNTY <b>Allegany</b>			13c. CITY OR TOWN <b>Cumberland</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS <b>709 St. Marys Ave.</b>						
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Jack</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Blair</b>												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>						16b. SOCIAL SECURITY NO. <b>War I</b>		17. INFORMANT ADDRESS <b>Mrs. Carrie A. Jack, Cumberland, Md. Wife</b>										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterial embolus</b> 4149 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>CAD</b> (b) } (c) } PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>CAD</b>																		
MEDICAL CERTIFICATION																		
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from <b>7/29</b> , 19 <b>80</b> , to <b>7/29</b> , 19 <b>80</b> , that (I) (we) lost saw the deceased alive on <b>7/29</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																		
22b. SIGNATURE <b>H. HAZEMOS</b> DEGREE <b>MD</b>										ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>7/30/80</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>P. B. HAZEMOS</b>										22e. ADDRESS <b>302 Schley St. Cumberland</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>					23b. DATE <b>Aug. 1, 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cumberland, Allegany, Md.</b>								
24. FUNERAL DIRECTOR NAME <b>James F. Scarpelli, Cumberland, Md.</b>										25a. DATE REC'D. BY REGISTRAR <b>AUG 04 1980</b>			25b. REGISTRAR'S SIGNATURE <b>Henry K. [Signature]</b>					



April 22, 1965

White

Male

Albany

USA

Harvard

Department of Psychology

Cambridge

Department of Psychology

200 St. Mary Ave.

Cambridge

Harvard

MA

Very Sincerely

John Locke

Rev. Carrie A. Lock, Cambridge, MA

Mr. I.

Rev.

Apr. 1, 1965

United

Cambridge, Massachusetts

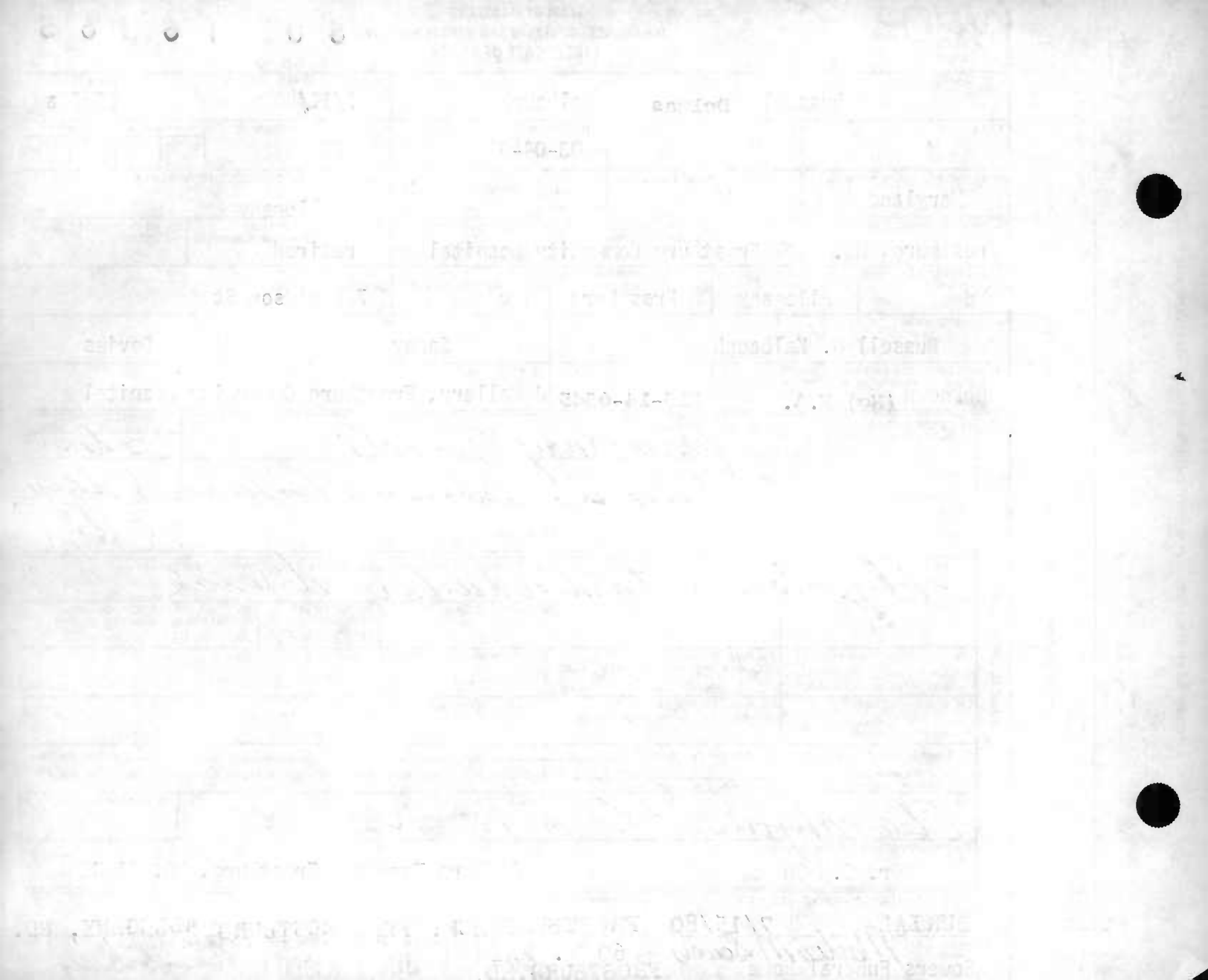
Cambridge, Massachusetts

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		8 0 1 6 5 6 5				REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
Russell Delmas Kalbaugh								7/13/80		12:30a M	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN	
M		W		03-04-08		72					
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		9b. CITIZEN OF WHAT COUNTRY?		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		USA				Allegany MD.					
12. CITY OR TOWN OF DEATH		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		15. KIND OF BUSINESS OR INDUSTRY					
Frostburg, MD.		Frostburg Community Hospital		retired							
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		17. STATE		18. COUNTY		19. CITY OR TOWN		20. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21. STREET ADDRESS	
Md		Allegany		Frostburg				YES		7 Davidson St	
22. FATHER'S NAME FIRST MIDDLE LAST		23. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		24. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		25. SOCIAL SECURITY NO.		26. INFORMANT		27. ADDRESS	
Russell B. Kalbaugh		Saney Davies		unknown (No)		215-14-6545		J Mallery, Frostburg Community Hospital			
28. CAUSE OF DEATH (Enter only one cause per line 1a, 1b, and 1c.)		29. PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		30. DUE TO, OR AS A CONSEQUENCE OF		31. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
486-		Pulmonary Emboli		CHD and Pulmonary Congestion		2 hour					
		DUE TO, OR AS A CONSEQUENCE OF		Pneumonia		5 days					
		DUE TO, OR AS A CONSEQUENCE OF				5 days					
32. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)		33. HYPERTENSIVE CARDIOVASCULAR DISEASE									
34. 19a. DATE OF OPERATION		35. 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		36. 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		37. 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
38. 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		39. 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		40. 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
41. 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		42. 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		43. 21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
44. 22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
45. 22a. SIGNATURE		46. 22b. DEGREE		47. 22c. DATE SIGNED							
Charles H. Oh		M.D.									
48. 22d. PHYSICIAN'S NAME (TYPE OR PRINT)		49. 22e. ADDRESS									
Dr. C.H. Oh		48 Tarn Terrace, Frostburg, MD. 21532									
50. 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		51. 23b. DATE		52. 23c. NAME OF CEMETERY OR CREMATORY		53. 23d. LOCATION CITY OR TOWN COUNTY STATE					
BURIAL		7/15/80		FROSTBURG MEM. PK		FROSTBURG ALLEGANY, MD.					
54. 24. FUNERAL DIRECTOR NAME		55. 24b. ADDRESS		56. 25a. DATE REC'D. BY REGISTRAR		57. 25b. REGISTRAR'S SIGNATURE					
Sowers Funeral Home		60 W. MAIN FROSTBURG, MD.		JUL 17 1980		L. J. McCready					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 1 6 5 6 6			
FOR 1. STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) EDITH BERRY KIFER				2a. DATE OF DEATH MONTH DAY YEAR JULY 10, 1980			
3. SEX F				4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR Sept. 30, 1912	
6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.				7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				10. CITIZEN OF WHAT COUNTRY? U S A			
11. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				12. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY, MD.			
13. CITY OR TOWN OF DEATH Cumberland				14. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL			
15. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife				16. KIND OF BUSINESS OR INDUSTRY Own Home			
17. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Allegany			
13c. CITY OR TOWN Cresaptown				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13e. STREET ADDRESS 14400 inchester Road				14. FATHER'S NAME FIRST MIDDLE LAST William H. Bantz			
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Roberta Crabtree				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			
16b. SOCIAL SECURITY NO. 217 10 5280				17. INFORMANT ADDRESS William C. Kifer, 1318 Cascade Drive Youngstown, Ohio. 44515			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 5714 IMMEDIATE CAUSE (a) Chronic active Hepatitis DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				21d. INJURY OCCURRED 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			
21f. LOCATION STREET CITY OR TOWN COUNTY STATE				21g. DATE SIGNED 7-11-80			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				22b. SIGNATURE GARY L. WAGONER M.D.			
22c. DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22d. ADDRESS 925 BISHOP WALSH DRIVE, CUMBERLAND, MD. 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE July 13, 1980			
23c. NAME OF CEMETERY OR CREMATORY Sunset Mem. Park				23d. LOCATION CITY OR TOWN COUNTY STATE Allegany Co., Md.			
24. FUNERAL DIRECTOR HAFER FUNERAL HOME, 1302 NATIONAL HWY. LAVALLE, MD.				25. DATE REC'D. BY REGISTRAR JUL 21 1980			

EDITH FERRY KITE JULY 10, 1981 1:25P

ALFORD COUNTY

SACRED HEART HOSPITAL

ALFORD COUNTY

ALFORD COUNTY

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ALFORD COUNTY

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH THE OTHER VITAL RECORDS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17  
(VR A15 ME (5))  
15M 7/77

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 16567	
1. DECEASED NAME (TYPE OR PRINT)		FIRST Hugh		MIDDLE E.		LAST Kifer		2a. DATE KNOWN OF DEATH ESTIMATED		2b. HOUR	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 4/24/1917		6. AGE (IN YEARS) LAST BIRTHDAY 63 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 7/20/80	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Business Man		12b. KIND OF BUSINESS OR INDUSTRY	
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sacred Heart Hospital		12c. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Business Man		12d. KIND OF BUSINESS OR INDUSTRY					
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Md		13b. COUNTY Allegany		13c. CITY OR TOWN LaVale		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 871 National Highway			
14. FATHER'S NAME FIRST MIDDLE Jesse Kifer				15. MOTHER'S MAIDEN NAME MIDDLE Martha Fazzenbaker							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no				16b. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Ada Kifer				ADDRESS LaVale, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>410 -</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) <u>CORONARY OCCLUSION</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CORONARY SCLEROSIS</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SUDDEN	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>Benedict Skitarlic</u>				TITLE (SPECIFY) M.D. Deputy				DATE SIGNED 7/20/80			
EXAMINER'S NAME (TYPE OR PRINT) BEBEDICT SKITARLIC				ADDRESS RT.9 Cumberland, Md 21502							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 7/23/80		23c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery				23d. LOCATION CITY STATE Moscow A Md	
24. FUNERAL DIRECTOR NAME Eichhorn Funeral Home				ADDRESS Lonaconing, Md				25a. DATE REC'D. BY REGISTRAR JUL 25 1980		25b. REGISTRAR'S SIGNATURE	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1 - FOR STATE REGISTRAR		REG. NO. 8016568									
1 DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a DATE OF DEATH MONTH DAY YEAR		2b HOUR	
George		Russell		Kitz		miller		July 1, 1980		1:15P M	
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		7 UNDER 1 YEAR MONTHS DAYS		7 UNDER 74 HRS HOURS MIN	
Male		White		Oct 7 1906		73 YRS					
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
W. Va.		USA				Allegany County, MD.					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY		
Cumberland		Sacred Heart Hospital				Ret Farmer			Farming		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS	
W. Va		Mineral		Elk Garden				Rt # 1			
14 FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
William H. Kitzmiller				Carrie Wilson							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS							
No		235 60 3092		Mrs. Eloise Kitzmiller Elk Garden, Wv							
18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c. PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE 1a) <i>Dehydration, Aspiration?</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
1629 DUE TO, OR AS A CONSEQUENCE OF 1b) <i>On Hwy, Ca pneumonia</i>											
Conditions, if any, which gave rise to immediate cause 1a, stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF 1c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 1a:											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE <i>A. B. Flores</i>				DEGREE <i>MD</i>				22c DATE SIGNED			
22d PHYSICIAN'S NAME (TYPE OR PRINT)				22e ADDRESS							
A. B. Flores, M.D.				924 Seton Drive, Cumberland, MD 21502							
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE					
Burial		7-5-80		Queens Point com.		Keyser Mineral W. Va.					
24 FUNERAL DIRECTOR NAME				24b ADDRESS				25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
Burdick Funeral Home, Kitzmiller, MD 21538								JUL 9 1980		<i>[Signature]</i>	

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General 100-100000 100-100000 100-100000

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 1, 2, AND 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
30M 7/73

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR 1- STATE REGISTRAR		1- DECEASED NAME (TYPE OR PRINT)		FIRST James		MIDDLE Richard		LAST La Rue		2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> <input type="checkbox"/>		MONTH 7		DAY 27		YEAR 80		2b. HOUR 2a					
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 14, 1958		6. AGE (IN YEARS) (LAST BIRTHDAY) 21 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD		MONTH 7		DAY 27		YEAR 80		2d. HOUR 2a					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.											
10. CITY OR TOWN OF DEATH Frostburg				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frostburg Hosp. DOA				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) none				12b. KIND OF BUSINESS OR INDUSTRY											
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. STATE Maryland				13b. COUNTY Allegany				13c. CITY OR TOWN Frostburg				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS 100 E. Main St.			
14. FATHER'S NAME FIRST MIDDLE LAST Willard La Rue				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elsie Smith																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. none				17. INFORMANT ADDRESS Elsie LaRue, 4 Fairview St. Fbg. Md.															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxiation</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Strangulation</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>(Hanged Self)</u>																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes "					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																							
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>										TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER										DATE SIGNED 7-27-80			
EXAMINER'S NAME (TYPE OR PRINT) Benedict Skitarelic										ADDRESS R# 9, Cumberland, Md. 21502													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE July 29, 1980				23c. NAME OF CEMETERY OR CREMATORY Johnson Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Frostburg, Garrett, Md.											
24. FUNERAL DIRECTOR NAME Durst, Frostburg, Md, 21532				ADDRESS				25a. REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE											

AUG 1 1980

1990 249

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

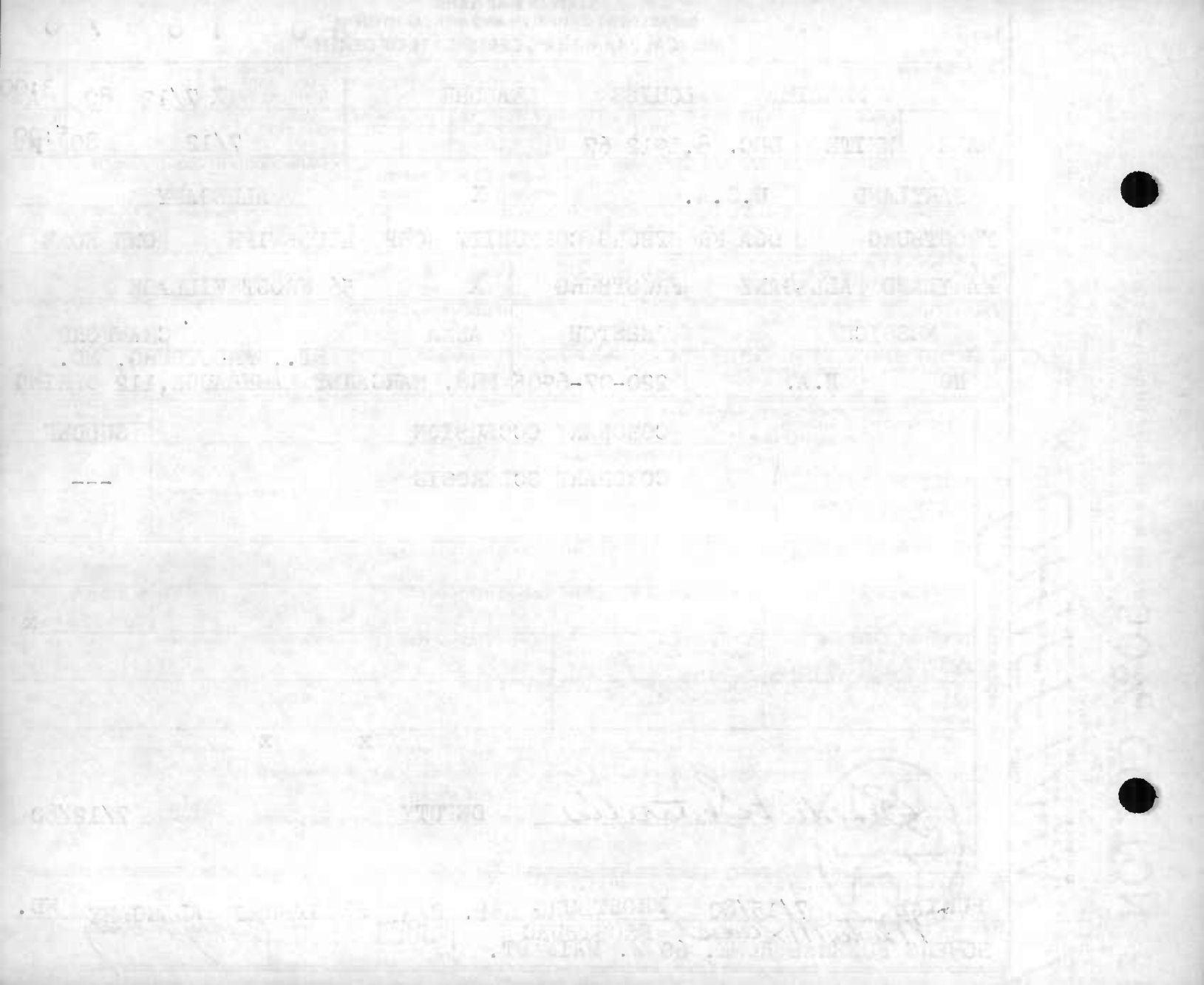
DHMH - 17  
(VR A15 ME (5))  
15M/7/77

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH		ESTI- MATED	MONTH	DAY	YEAR	2b. HOUR
NELLIE LOUISE LEASURE					7/12					1980	3:00 AM
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)	IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		2d. HOUR
MALE	WHITE	DEC. 8, 1912		67 YRS.	MONTHS		DAYS		7/12		5:00 AM
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
MARYLAND		U.S.A.				ALLEGANY MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
FROSTBURG		DOA FROSTBURG COMMUNITY HOSP				HOUSEWIFE		OWN HOME			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
MARYLAND		ALLEGANY		FROSTBURG		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		56 FROST VILLAGE			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
FIRST MESSICH MIDDLE PRESTON LAST				FIRST ANNA MIDDLE CRAWFORD LAST							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT							
NO		N.A.		220-07-6905		ST., FROSTBURG, MD. MRS. MARGARET LASHBAUGH, 112 SPRING					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) CORONARY OCCLUSION										SUDDEN	
410 - DUE TO, OR AS A CONSEQUENCE OF											
(b) CORONARY SCLEROSIS											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?	
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
				HOUR A.M. MONTH DAY YEAR							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION					
						STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED			
Benedict Skitaralis				M.D. DEPUTY				7/12/80			
EXAMINER'S NAME				ADDRESS							
(TYPE OR PRINT)											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY		STATE	
BURIAL		7/15/80		FROSTBURG MEM. PARK		FROSTBURG		ALLEGANY		MD.	
24. FUNERAL DIRECTOR'S NAME		24. FUNERAL HOME		25a. DATE RECEIVED BY REGISTRAR		25b. DATE RECEIVED BY REGISTRAR		25c. DATE RECEIVED BY REGISTRAR		25d. DATE RECEIVED BY REGISTRAR	
SOWERS FUNERAL HOME		60 W. MAIN ST.		JULY 17 1980							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		8 0 1 6 5 7 1				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) DOYLE H. LENHART				2a. DATE OF DEATH MONTH DAY YEAR JULY 27, 1980				2b. HOUR 9:30 A.M.	
3. SEX MALE		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 9 2 1904		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WV		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany County MD.			
10. CITY OR TOWN OF DEATH CUMBERLAND, MD.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY Coppers Co.	
13a. STATE Md.				13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Frederick Lenhart				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sylvia Nesmith					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 232-10-5523		17. INFORMANT ADDRESS Shirley M. Lee, Box 2, Springfield, WV 26763			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Auto MI</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ASCVD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u> <u>20 days</u> <u>?</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from <u>7-7-80</u> , 19 <u>80</u> , to <u>7-27</u> , 19 <u>80</u> , that (1) (we) last saw the deceased alive on <u>7-26</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (2) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Dr. Anthony J. Bollino</u>				DEGREE <u>MD</u>				22c. DATE SIGNED <u>27 July 80</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. ANTHONY J. BOLLINO, JR.				22e. ADDRESS 955 FREDERICK ST. CUMBERLAND, MD. 21502					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/30/80		23c. NAME OF CEMETERY OR CREMATORY Forest Glen Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Greenspring, Hampshire WV			
24. FUNERAL DIRECTOR NAME Keith S. Shaffer				ADDRESS 26757 230 E. Main St., Romney WV		25a. RECEIVED BY <u>Aug 1 1980</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			



1 2 3 4

DATE: JULY 27, 1980

TIME: 10:00 AM

LOCATION: Allegheny County, Pa.

REASON: [illegible]

BY: [illegible]

FOR: [illegible]

IN: [illegible]

AT: [illegible]

ON: [illegible]

OF: [illegible]

TO: [illegible]

FROM: [illegible]

THAT: [illegible]

AND: [illegible]

WHICH: [illegible]

AND: [illegible]

AND: [illegible]

AND: [illegible]

AND: [illegible]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD WRITE "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETURN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 6 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

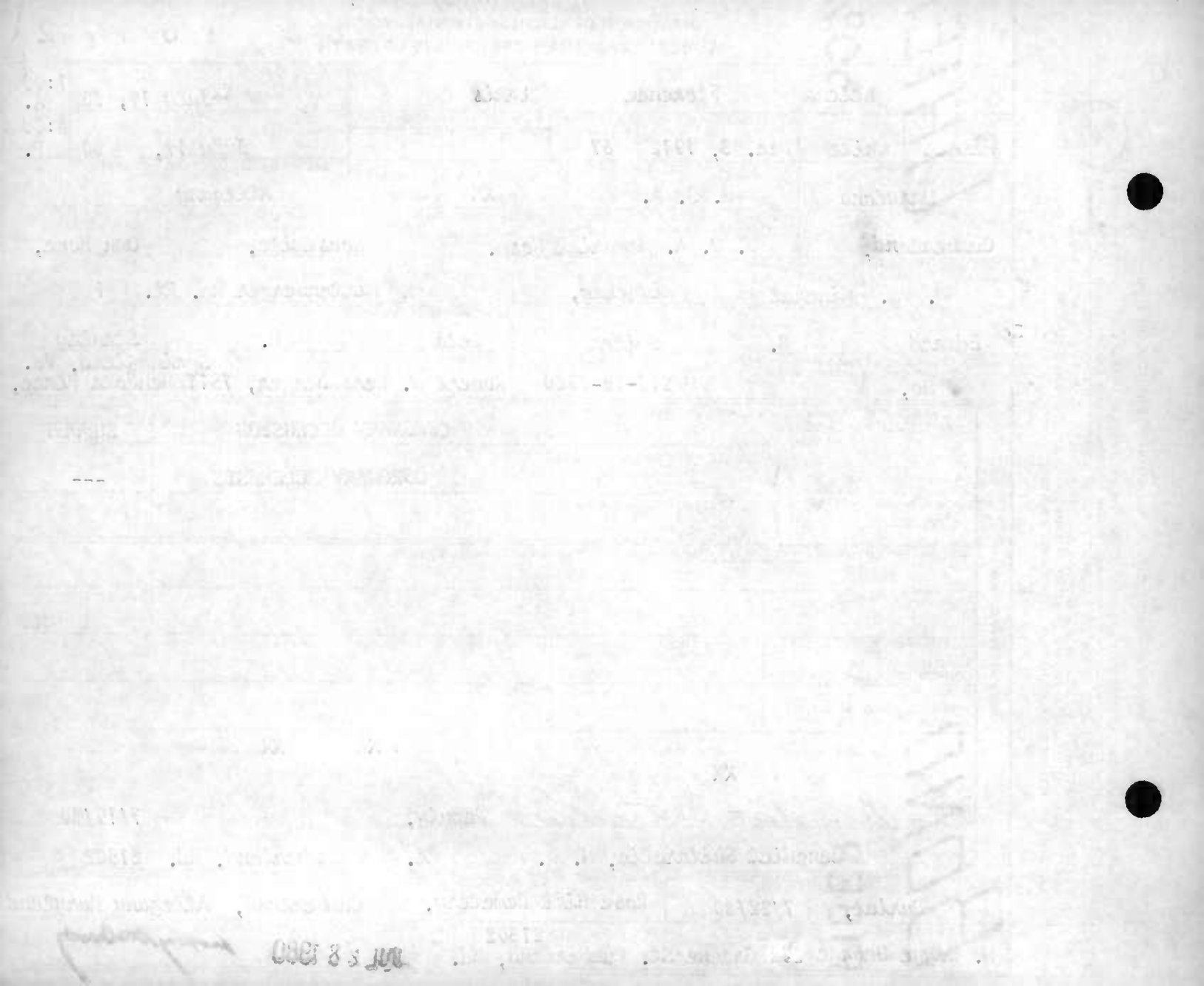
DHMH - 17  
(VR A15 ME(5))  
15M 7/76

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST Helena		MIDDLE Florence		LAST Lewis		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> July 19, 1980		2b. HOUR 1:00 A.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 3, 1912		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD July 19, 1980	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany		MD.		2d. HOUR 8:00 P.M.	
10. CITY OR TOWN OF DEATH Cumberland,		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) D. O. A. Memorial Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife,		12b. KIND OF BUSINESS OR INDUSTRY Own Home,					
13a. STATE W. Va.		13b. COUNTY Mineral		13c. CITY OR TOWN Ridgeley,		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Miltenerberger Rd. Rt. # 1			
14. FATHER'S NAME FIRST MIDDLE LAST Edward B. Spicer		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Zeta M. Stanley		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No,		16b. SOCIAL SECURITY NO. 217-10-7720		17. INFORMANT ADDRESS Robert W. Hershberger, 7511 Mendota Place,		Springfield, Va.	
MEDICAL CERTIFICATION		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>410 -</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>CORONARY SCLEROSIS</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CORONARY OCCLUSION</u> DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SUDDEN ---	
		PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).									
		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>		TITLE (SPECIFY) M.D. Deputy,		MEDICAL EXAMINER				DATE SIGNED 7/19/80			
EXAMINER'S NAME (TYPE OR PRINT) Benedict Skitarelic, M. D.		ADDRESS Rt. # 9 Cumberland, Md.		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial,		23b. DATE 7/22/80		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery,		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland, Allegany Maryland	
24. FUNERAL DIRECTOR NAME H. Wayne George		ADDRESS 202 Greene St. Cumberland, Md.		25a. DATE REC'D. BY REGISTRAR JUL 28 1980		25b. REGISTRAR'S SIGNATURE <u>Harry H. Hershberger</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please retain the certificate for 24 hours after death. Please retain the certificate for 24 hours after death.

BP

DHMH - 16 60M 7/73  
(VR A 15 (4))

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death. Page 3 should be filed within 72 hours after death. Page 4 should be filed within 72 hours after death. Page 5 should be filed within 72 hours after death. Page 6 should be filed within 72 hours after death. Page 7 should be filed within 72 hours after death. Page 8 should be filed within 72 hours after death. Page 9 should be filed within 72 hours after death. Page 10 should be filed within 72 hours after death. Page 11 should be filed within 72 hours after death. Page 12 should be filed within 72 hours after death. Page 13 should be filed within 72 hours after death. Page 14 should be filed within 72 hours after death. Page 15 should be filed within 72 hours after death. Page 16 should be filed within 72 hours after death. Page 17 should be filed within 72 hours after death. Page 18 should be filed within 72 hours after death. Page 19 should be filed within 72 hours after death. Page 20 should be filed within 72 hours after death. Page 21 should be filed within 72 hours after death. Page 22 should be filed within 72 hours after death. Page 23 should be filed within 72 hours after death. Page 24 should be filed within 72 hours after death. Page 25 should be filed within 72 hours after death. Page 26 should be filed within 72 hours after death. Page 27 should be filed within 72 hours after death. Page 28 should be filed within 72 hours after death. Page 29 should be filed within 72 hours after death. Page 30 should be filed within 72 hours after death. Page 31 should be filed within 72 hours after death. Page 32 should be filed within 72 hours after death. Page 33 should be filed within 72 hours after death. Page 34 should be filed within 72 hours after death. Page 35 should be filed within 72 hours after death. Page 36 should be filed within 72 hours after death. Page 37 should be filed within 72 hours after death. Page 38 should be filed within 72 hours after death. Page 39 should be filed within 72 hours after death. Page 40 should be filed within 72 hours after death. Page 41 should be filed within 72 hours after death. Page 42 should be filed within 72 hours after death. Page 43 should be filed within 72 hours after death. Page 44 should be filed within 72 hours after death. Page 45 should be filed within 72 hours after death. Page 46 should be filed within 72 hours after death. Page 47 should be filed within 72 hours after death. Page 48 should be filed within 72 hours after death. Page 49 should be filed within 72 hours after death. Page 50 should be filed within 72 hours after death. Page 51 should be filed within 72 hours after death. Page 52 should be filed within 72 hours after death. Page 53 should be filed within 72 hours after death. Page 54 should be filed within 72 hours after death. Page 55 should be filed within 72 hours after death. Page 56 should be filed within 72 hours after death. Page 57 should be filed within 72 hours after death. Page 58 should be filed within 72 hours after death. Page 59 should be filed within 72 hours after death. Page 60 should be filed within 72 hours after death. Page 61 should be filed within 72 hours after death. Page 62 should be filed within 72 hours after death. Page 63 should be filed within 72 hours after death. Page 64 should be filed within 72 hours after death. Page 65 should be filed within 72 hours after death. Page 66 should be filed within 72 hours after death. Page 67 should be filed within 72 hours after death. Page 68 should be filed within 72 hours after death. Page 69 should be filed within 72 hours after death. Page 70 should be filed within 72 hours after death. Page 71 should be filed within 72 hours after death. Page 72 should be filed within 72 hours after death. Page 73 should be filed within 72 hours after death. Page 74 should be filed within 72 hours after death. Page 75 should be filed within 72 hours after death. Page 76 should be filed within 72 hours after death. Page 77 should be filed within 72 hours after death. Page 78 should be filed within 72 hours after death. Page 79 should be filed within 72 hours after death. Page 80 should be filed within 72 hours after death. Page 81 should be filed within 72 hours after death. Page 82 should be filed within 72 hours after death. Page 83 should be filed within 72 hours after death. Page 84 should be filed within 72 hours after death. Page 85 should be filed within 72 hours after death. Page 86 should be filed within 72 hours after death. Page 87 should be filed within 72 hours after death. Page 88 should be filed within 72 hours after death. Page 89 should be filed within 72 hours after death. Page 90 should be filed within 72 hours after death. Page 91 should be filed within 72 hours after death. Page 92 should be filed within 72 hours after death. Page 93 should be filed within 72 hours after death. Page 94 should be filed within 72 hours after death. Page 95 should be filed within 72 hours after death. Page 96 should be filed within 72 hours after death. Page 97 should be filed within 72 hours after death. Page 98 should be filed within 72 hours after death. Page 99 should be filed within 72 hours after death. Page 100 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 0	1 6 5 7 3
1. FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Ida A. Lewis</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>July 28, 1980</b>			2b. HOUR <b>1:40a</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>March 13, 1898</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD.					
10. CITY OR TOWN OF DEATH <b>Rawlings</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Route 1</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>				
13a. STATE <b>W. Va.</b>		13b. COUNTY <b>Mineral</b>		13c. CITY OR TOWN <b>Ridgeley</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Route 1, Miltenberger Road</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Arthur H. Lloyd</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Margaret Rumer</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Mrs. Helen Smith, Rrawlings, Md. Daughter</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MALNUTRITION + CAEMENIA</b> <b>1809</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>WIDESPREAD CARCINOMA OF CERVIX -</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 YEARS</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>7/12</b> 19 <b>80</b> , to <b>7/28</b> 19 <b>80</b> , that (I) (we) lost the deceased on <b>7/28</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>James M. Raver</b>					DEGREE <b>MD</b>			22c. DATE SIGNED <b>7/28/80</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JAMES M. RAVER</b>					22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>July 30, 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Abe Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Near Ridgeley, W. Va.</b>				
24. FUNERAL DIRECTOR NAME <b>James F. Scarpelli, Cumberland, Md.</b>					25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <b>Henry H. H. H.</b>				

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[Faint, mostly illegible handwritten notes and signatures covering the middle section of the page]

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGES 5 FOR YOUR FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (5))  
30M 7/73

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 16574			
1. FOR STATE REGISTRAR										2a. DATE KNOWN OF DEATH		2b. DATE OF ESTIMATED DEATH	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>RUDOLPH GRANTLEY LEWIS</b>										MONTH DAY YEAR <b>7/2 1980</b>		2b. HOUR <b>2:00 A M</b>	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 16, 1900</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>79</b> YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>JULY 2, 1980</b>		2d. HOUR <b>2:00 A M</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ALLEGANY MD.</b>			
10. CITY OR TOWN OF DEATH <b>FROSTBURG</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>DOA FROSTBURG COMMUNITY HOSP.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>BARTENDER</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>EAGLES</b>	
13a. STATE <b>MARYLAND</b>				13b. COUNTY <b>ALLEGANY</b>		13c. CITY OR TOWN <b>FROSTBURG</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>217 UPPER CONSOL ROAD</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>JOHN LEWIS</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ANNIE YATES</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>N.A.</b>		17. INFORMANT ADDRESS <b>FROSTBURG, MD. MRS. RUDOLPH LEWIS, 217 UPPER CONSOL RD.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>CORONARY SCLEROSIS</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>---</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>SUDDEN</b>													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH P.M. 19				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>				TITLE (SPECIFY) <b>DEPUTY</b>				MEDICAL EXAMINER				DATE SIGNED <b>7/2/80</b> <b>21502</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>BENEDICT SKITARELIC, M.D.</b>				ADDRESS <b>BALTIMORE PIKE, CUMBERLAND, MD.</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>				23b. DATE <b>7/4/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>FROSTBURG MEM. PARK</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>FROSTBURG ALLEGANY MD.</b>			
24. FUNERAL DIRECTOR NAME <i>Funeral M. Sowers</i> <b>FROSTBURG, SOWERS FUNERAL HOME, 60 W. MAIN ST.,</b>				25a. DATE REC'D. BY REGISTRAR <b>JUL 7 1980</b>				25b. REGISTRAR'S SIGNATURE <i>propy McCreedy</i>					

MEDICAL CERTIFICATION

TABLE IV

29

CONTRACT ADMIN.

THE NATIONAL ARCHIVES



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

1- FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8016575 REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) <b>EMERSON E LOAR</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>JULY 12, 1980</b>				2b. HOUR <b>7:40 PM</b>			
3 SEX <b>Male</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>August 14, 1900</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>79</b> YRS.		7a. IF UNDER 1 YEAR MONTHS DAYS		7b. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD.					
10 CITY OR TOWN OF DEATH <b>CUMBERLAND, MD.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MEMORIAL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Doctor</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Dentist</b>			
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>LaVale</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>283 National Highway</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Hoffman E. Loar</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rheta Boor</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>218-38-1306</b>		17 INFORMANT ADDRESS <b>Sarah C. Loar, LaVale, Maryland</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CVA</b> <b>436-</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>15 days</b>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (his hospital) attended the deceased from <b>7/12</b> 19 <b>80</b> to <b>7/12</b> 19 <b>80</b> , that (I) (we) lost <b>show the deceased alive on above; (I) (we) (did not) view the body after death.</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated											
22b. SIGNATURE <b>T. Williams</b>				DEGREE <b>M.D.</b>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>13 July 80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>T. WILLIAMS, M.D.</b>				22e. ADDRESS <b>MEMORIAL MED. BLDG., CUMBERLAND, MD.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>July 15, 80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Lawn Mem. Garden</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>LaVale Allegany Maryland</b>			
24 FUNERAL DIRECTOR NAME ADDRESS <b>KIGHT FUNERAL HOME CUMBERLAND MARYLAND</b>				25a. DATE REC'D. BY REGISTRAR <b>JUL 17 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Tracy McCreedy</b>					

BP \_\_\_\_\_

EMERSON E LGAR JULY 12, 1980 7:40P

CUMBERLAND, MD. MEMORIAL HOSPITAL

CUB

T. WILLIAMS, M.D. MEMORIAL MED. BLDG., CUMBERLAND, MD.

RIGHT FUNERAL HOME

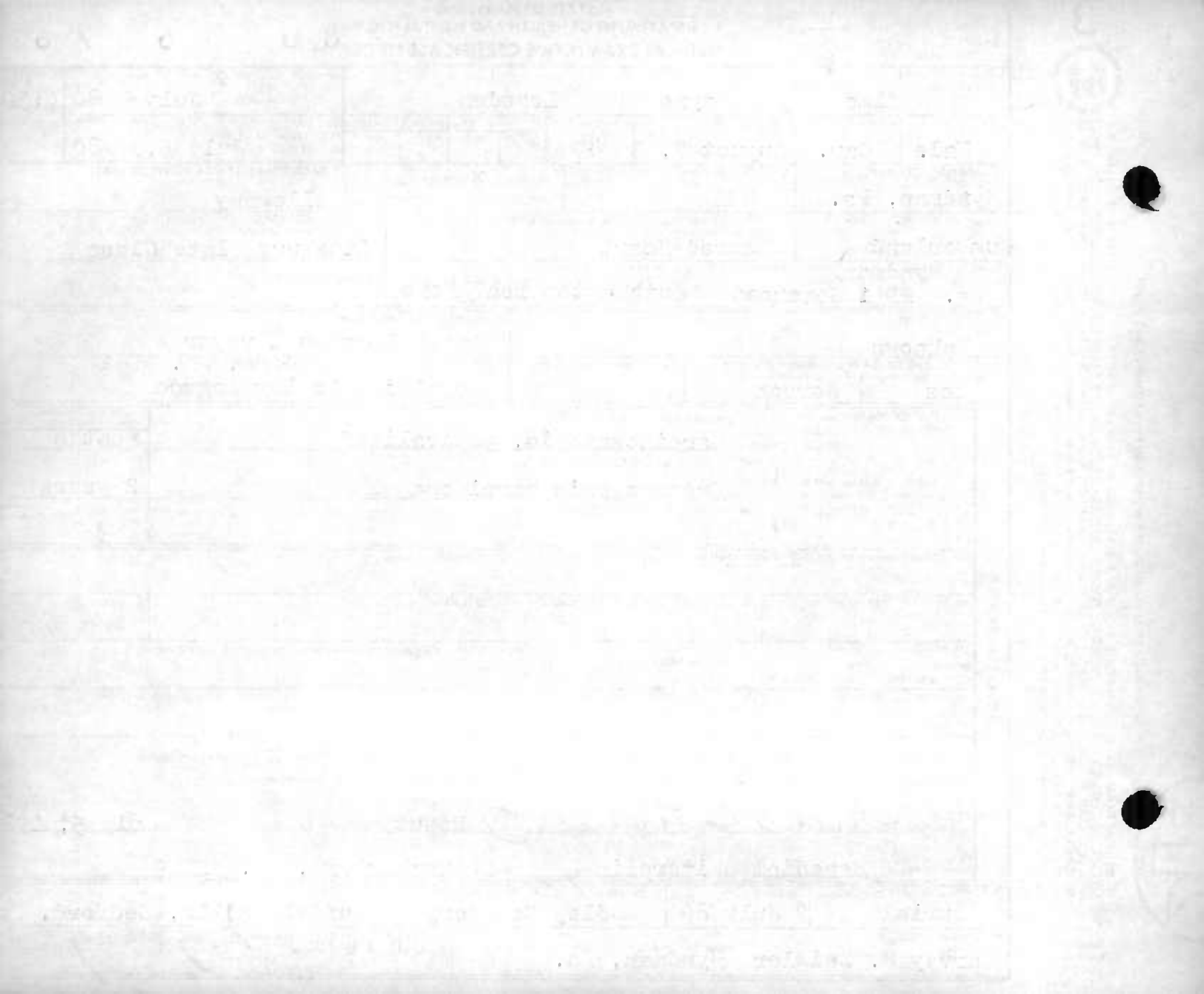
BP

DHMH - 17  
(VR A15 ME (5))  
15M/7/77

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 16576	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Elmo Wayne Logsdon						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <input type="checkbox"/> July 5, 1980		2b. HOUR MIN 6:30			
3. SEX Male		4. RACE Cau.		5. DATE OF BIRTH MONTH DAY YEAR August 7, 1930		6. AGE (IN YEARS LAST BIRTHDAY) 49 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Hyndman, Pa. RD				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany	
10. CITY OR TOWN OF DEATH Cumberland				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sacred Heart				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Pittsburg Plate Glass		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF MANUSCRIPT HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Pa. RD 1 Somerset Southampton Tsk						13d. INSIDE CITY LIMITS? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		13e. STREET ADDRESS			
14. FATHER'S NAME FIRST MIDDLE LAST Unknown						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mabel Logsdon Shroyer					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. Korean		17. INFORMANT Hyndman, Pa. RD 1 Geraldine Lepley Logsdon					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis, generalized</u> 1629 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which } gave rise to immediate } cause (a) stating the under- } lying cause lost. } (b) <u>Bronchogenic carcinoma</u> } DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH months 2 years	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>				TITLE (SPECIFY) M.D. Deputy				DATE SIGNED July 5, 1980			
EXAMINER'S NAME (TYPE OR PRINT) <u>Benedict Skitarelic</u>				ADDRESS <u>Cumberland, Md. RD 9</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				23b. DATE 7 July 80		23c. NAME OF CEMETERY OR CREMATORY Madley Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Buffalo Mills, Bedford, Pa			
24. FUNERAL DIRECTOR NAME ADDRESS Harvey H. Zeigler Hyndman, Pa.						25a. DATE REC'D. BY REGISTRAR JUL 10 1980		25b. REGISTRAR'S SIGNATURE			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8016577 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>Hilda NMI Major</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>July 2, 1980</b>			
3. SEX <b>Female</b>				2b. HOUR <b>9:00a</b>			
4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>2-2-1900</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS <b>80</b>		7. UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany County, Md.</b>	
10. CITY OR TOWN OF DEATH <b>Cumberland</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Sacred Heart Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md</b> 13b. COUNTY <b>Allegany</b> 13c. CITY OR TOWN <b>Lonaconing</b>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE <b>James Major</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE <b>Isabel Wilson</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>				16b. SOCIAL SECURITY NO.			
17. INFORMANT ADDRESS <b>Mrs. Faye Brakeall Short, W.Va</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Embolus</b> 4/10 - DUE TO, OR AS A CONSEQUENCE OF (b) <b>Mural Thrombus</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c) <b>Artrial F. bullation</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12 days</b> <b>?</b> <b>2 years</b>							
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Acvd</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>July 1, 1980</b> to <b>July 2, 1980</b> , that (I) (we) lost saw the deceased alive on <b>July 1, 1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Leslie Miles, M.D.</b>				22c. DATE SIGNED <b>7.2.80</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Leslie Miles, M.D.</b>	
22e. ADDRESS <b>55 Jackson St., Lonaconing, Md. 21539</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7/5/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Lonaconing A. Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Eichhorn Funeral Home</b>				25a. DATE REC'D. BY REGISTRAR <b>8/1/80</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 0 1 6 5 7 8  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>JAMES OSBORNE MCDONALD</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JULY 27, 1980</b>			2b. HOUR <b>11:00A</b>				
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11 22 1907</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>73</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS <b>0 0</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ALLEGANY COUNTY, MD</b>				
10. CITY OR TOWN OF DEATH <b>Cumberland</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SACRED HEART HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Laborer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>			13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Barton</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>Barton Md.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Henry McDonald</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Bessie Miller</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>None</b>		17. INFORMANT ADDRESS <b>Miss Eileen McDonald Barton Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>acute renal failure</b> <b>4414</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Resection abd. aortic aneurysm</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>-----</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>3 days</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a): <b>-----</b>										
19a. DATE OF OPERATION <b>7/25/1980</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>abd. aortic aneurysm</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) <b>-----</b>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>-----</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>-----</b>					
22a. I certify that (I) (this hospital) attended the deceased from <b>7-5</b> , 19 <b>80</b> , to <b>7-27</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>7-26</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Thomas J. Devlin</b>			DEGREE <b>MD.</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>7-28-80</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>THOMAS J. DEVLIN, M.D.</b>					22e. ADDRESS <b>55 JACKSON STREET, LONACONING, MD. 21539</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>7-29-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Laurel Hill Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Moscow Mills Allegany Md.</b>			
24. FUNERAL DIRECTOR NAME <b>BOAL'S Funeral Service</b>					25a. AUG. BY REGISTRAR <b>-----</b>		25b. REGISTRAR'S SIGNATURE <b>-----</b>			





JULY 27, 1980 11:07A

JAMES OSBORNE MEDICATED

SS I 23

ALLEANY COUNTY

SACRED HEART HOSPITAL

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Admission

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Female

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San Juan County, New Mexico

22 JACKSON STREET, TOWSON, MD. 21286

THOMAS J. DEVLIN, M.D.

200

WESTERN HILL

WV 20

Page 1

WILKINSON STREET

1011 1st St

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING;" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
30M 7/73

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST John			MIDDLE Joseph			LAST McKenzie			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 7-7-80 <sub>19</sub> 6:45p <sub>M</sub>			2b. HOUR								
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 19, 1943		6. AGE (IN YEARS) LAST BIRTHDAY YRS. 43		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD 7-7-80 <sub>19</sub> 6:45p <sub>M</sub>			2d. HOUR								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.											
10. CITY OR TOWN OF DEATH Cumberland				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sacred Heart Hospital								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Brick Worker				12b. KIND OF BUSINESS OR INDUSTRY Brick Yard							
13a. STATE Maryland				13b. COUNTY Allegany				13c. CITY OR TOWN Frostburg				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS Rt. #2, Frostburg, Maryland 21532							
14. FATHER'S NAME FIRST MIDDLE LAST Austin J. Mc Kenzie				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Betty Werner				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes Nat. Guard								16b. SOCIAL SECURITY NO. 218-50-0370				17. INFORMANT ADDRESS Rt. 2 Mrs. Judith Mc Kenzie, Frostburg, Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ruptured Heart; Ruptured Liver</u> (b) <u>(Driver in two car accident)</u> (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																							
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY HOUR:AM. MONTH DAY YEAR 5:50 P.M. 7-7-80 <sub>19</sub>						21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Driver in two car collision											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK						21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Rt. #40						21f. LOCATION STREET CITY OR TOWN COUNTY STATE Top of Savage Mt., Allegany, Maryland											
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																							
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>										TITLE (SPECIFY) Deputy				DATE SIGNED 7-7-80									
EXAMINER'S NAME Benedict Skitarelic, M.D.										ADDRESS R#9, Cumberland, Maryland 21502													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial						23b. DATE July 16, 80		23c. NAME OF CEMETERY OR CREMATORY Finzel Cemetery						23d. LOCATION CITY OR TOWN COUNTY STATE Finzel, Garrett, Md.									
24. FUNERAL DIRECTOR NAME Durst;										ADDRESS Frostburg, Maryland				25a. DATE REC'D BY REGISTRAR JUL 16 1980				25b. REGISTRAR'S SIGNATURE					



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 16580									
1. FOR STATE REGISTRAR										2a. DATE KNOWN OF DEATH		2b. HOUR							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Violet Mildred McKenzie</b>										ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>7 30 1980</b>		3:30 PM							
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 14 1914</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>66</b>		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>7 30 1980</b>		2d. HOUR <b>3:30 PM</b>					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD.							
10. CITY OR TOWN OF DEATH <b>Cumberland</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>At Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housekeeper</b>				12b. KIND OF BUSINESS OR INDUSTRY							
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Allegany</b>				13c. CITY OR TOWN <b>Cumberland</b>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS <b>12107 Marigold Ave. S.W.</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>George B Grove</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Pearl Robinson</b>				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>216-80-5689</b>				17. INFORMANT ADDRESS <b>Bernard A. McKenzie 12107 Marigold Ave. Cumberland, Md S.W.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis; generalized</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>Carcinoma of <del>breast</del> Breast</b> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1749</b> Years									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																			
19a. DATE OF OPERATION <b>1960</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b>Mastectomy</b>								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>				TITLE (SPECIFY) <b>Deputy</b>				DATE SIGNED <b>7:31:80</b>				MEDICAL EXAMINER							
EXAMINER'S NAME (TYPE OR PRINT) <b>Benedict Skitarelic m.D.</b>				ADDRESS <b>R#9 Cumberland Maryland 21502</b>															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>Aug 2/80</b>				23c. NAME OF CEMETERY OR CREMATORY <b>S.S. Peter &amp; Paul Cem</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cumberland Allegany Maryland</b>							
24. FUNERAL DIRECTOR NAME <b>Silcox-Merritt Funeral Service</b>				ADDRESS <b>Cumberland, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>AUG 04 1980</b>				25b. REGISTRAR'S SIGNATURE <b>P. H. H. H.</b>							

MEDICAL CERTIFICATION

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Journal of Interpersonal Violence 27(12)

Product:

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please have the retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		7. REG. NO.		8. 0		1. 6		5. 8		1. 1	
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR			
FIRST MARY				MIDDLE ELIZABETH				LAST MC LANE			
JULY 12, 1980				2340PM							
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS	
Female		White		03 03 04		76		YRS		MONTHS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U.S.A.				Allegany				MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
CUMBERLAND		MEMORIAL HOSPITAL		Housewife		Own Home					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. CITY OR TOWN				13b. INSIDE CITY LIMITS?			
13a. STATE Maryland				13b. COUNTY Allegany				13c. STREET ADDRESS			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
FIRST William				FIRST Ogorretta				LAST Clary			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS			
No				218-62-5902				Oliver W. Mc Lane, Frostburg, Md. 21532			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY.										11:40 P.M. on 12 July 1980	
IMMEDIATE CAUSE (a) Acute coronary occlusion with cardiac arrest.											
DUE TO, OR AS A CONSEQUENCE OF											
(b) Unstable angina										Onset: 30 May 1980	
DUE TO, OR AS A CONSEQUENCE OF											
(c) C.A.D., advanced											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
Aneurysm, abdominal aorta. Arteriosclerotic cardiovascular diseases											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
				HOUR A.M. MONTH DAY YEAR							
				P.M. 19							
21d. INJURY OCCURRED				21e. PLACE OF INJURY				21f. LOCATION			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the deceased) attended the deceased from 2 November 1977 to 12 July 1980, that (I) (the deceased) saw the deceased alive on 12 July 1980, and that in (my) (the deceased's) opinion death occurred on the date and hour and from the causes stated above, (I) (the deceased) (did not) view the body after death.											
22b. SIGNATURE				DEGREE				22c. DATE SIGNED			
W. Alfred Van Ormer, M.D.								14 July 1980			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
DR. W. A. VAN ORMER				MEMORIAL HOSPITAL MEDICAL BLDG. CUMBERLAND, MD. 21502							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. DATE REC'D. BY REGISTRAR	
Burial				July 15, 1980		St. Michaels Cemetery		Frostburg, Allegany, Md.		JUL 22 1980	
24. FUNERAL DIRECTOR				24b. ADDRESS				24c. REGISTRAR'S SIGNATURE			
NAME				Durst Funeral Home, Frostburg, Md. 21532				24d. REGISTRAR'S SIGNATURE			

BP

First Funeral Home, Frederick, Md. 21532

Burial July 15, 1980 St. Michaels Cemetery, Frederick, Allegany, Md.

MEMORIAL HOSPITAL MEDICAL BLDG.  
CUMBERLAND, MD. 21502

DR. W. A. VAN DUSEN

No

Oliver W. Mc Lane, Frederick, Md. 21532

William W. Baker, Oronoke, Maryland

Allegany, Frederick, Maryland, 168 E. Main St.

CUMBERLAND MEMORIAL HOSPITAL, Housewife, Own Home

Maryland, Allegany

White

X

MARY ELIZABETH MC LANE JULY 15, 1980

2240PM



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 0 1 6 5 8 2	
1. FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <u>JAMES</u> <u>G</u> <u>McPARTLAND</u>					2a. DATE OF DEATH MONTH DAY YEAR <u>07/07/1980</u>			2b. HOUR <u>6:10 A.M.</u>			
3 SEX <u>Male</u>		4 RACE <u>White</u>		5 DATE OF BIRTH MONTH DAY YEAR <u>12</u> <u>14</u> <u>1910</u>		6 AGE (IN YEARS LAST BIRTHDAY) <u>69</u>		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <u>YRS.</u>		8. IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Md</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <u>Allegany</u> <u>MD</u>					
10 CITY OR TOWN OF DEATH <u>Frostburg</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Community Hospital</u>				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <u>Retired</u>		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>Md</u> 13b. COUNTY <u>Allegany</u> 13c. CITY OR TOWN <u>Moscow</u>					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <u>Rt 1 Barton, Md</u>				
14 FATHER'S NAME FIRST MIDDLE LAST <u>Bernard</u> <u>Mc</u> <u>Partland</u>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Elizabeth</u> <u>Brennan</u>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO		17 INFORMANT ADDRESS <u>Mrs. Nellie McPartland Barton, Md</u>							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bilateral Bronchopneumonia</u> <u>7339</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Spinocerebellar degeneration</u> (c) <u>Arteriosclerotic heart disease</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>2 years</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Previous history of myocardial infarction</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22a. SIGNATURE <u>Chang H. OH, M.D.</u>					DEGREE <u>M.D.</u>					22c. DATE SIGNED <u>7/7/80</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>CHANG H. OH, M.D.</u>					22e. ADDRESS <u>48 Tarn Terrace, Frostburg, Md</u>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>7/9/80</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Michaels Cemetery</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Frostburg A. Md</u>					
24 FUNERAL DIRECTOR Name <u>Eichhorn Funeral Home</u> ADDRESS <u>Lonaconing, Md</u>					25a. DATE REC'D. BY REGISTRAR <u>JUL 9 1980</u>		25b. REGISTRAR'S SIGNATURE <u>Robert McHenry</u>				

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1000 JUL 8 1980

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8016583			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>EDDIE LAWRENCE MYERS</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>JULY, 28, 1980</b>			
3. SEX <b>Male</b>				2b. HOUR <b>6:24 P.M.</b>			
4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>May 9, 1924</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>56</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Ala.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ALLEGANY COUNTY, MD.</b>	
10. CITY OR TOWN OF DEATH <b>Cumberland</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SACRED HEART HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. STREET ADDRESS			
13a. STATE <b>Md.</b>		13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Cumberland</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Freeman Myers</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Emma Talley</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>412-44-5475</b>		17. INFORMANT ADDRESS <b>Mrs. Wilma Robison, Cumberland, Md. Sister</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic adenocarcinoma of</b> <b>1629</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>the lung with metastases</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>a superior vena cava obstruction</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>5-10</b> 19 <b>80</b> , to <b>7-28</b> 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>7-28</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>John N. Mehan</b>				DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>7-29-80</b>	
23a. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOHN N. MEHANNA, M.D.</b>				22e. ADDRESS <b>909-B SETON DRIVE, CUMBERLAND, MD. 21502</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>July 31, 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cumberland, Allegany, Md.</b>	
24. FUNERAL DIRECTOR NAME <b>SCARPELLI FUNERAL HOME</b>		ADDRESS <b>108 VIRGINIA AVE CUMBERLAND, MD. 21502</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 04 1980</b>		25b. REGISTRAR'S SIGNATURE <b>P. H. H. H.</b>	

100-100000

EDDIE LAWRENCE MYERS JULY 28, 1922 2:00 P.

Ala. wife May 7, 1924 ALLIANCE COUNTY

Gumbertland SACRED HEART HOSPITAL No. Allamany Gumbertland

Yes War II Yes - No - Mrs. William Gumbertland, No. 2100

the company was established in 1914 and has since that time been in continuous operation.

JOHN H. EVANS, M.D. 200-B BETHEL DRIVE, GUMBERTLAND, MT. 21502

BUCHAL JULY 31, 1980 108 VIRGINIA AVE. GUMBERTLAND, MT. 21502 AUG 4 1980

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
15M/7/77

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST Richard		MIDDLE M		LAST Oster		2a. DATE KNOWN OF DEATH ESTIMATED		MONTH 07		DAY 17		YEAR 80		7b. HOUR 3:30p			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 4, 1932		6. AGE (IN YEARS LAST BIRTHDAY) 48 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD		MONTH DAY YEAR 07-17-80		7d. HOUR 3:30p			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Allegany				MD.			
10. CITY OR TOWN OF DEATH Cumberland				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sacred Heart Hospital---DOA				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Navy				12b. KIND OF BUSINESS OR INDUSTRY Military							
13a. STATE Maryland				13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS North Cresap Street									
14. FATHER'S NAME FIRST MIDDLE LAST William Max Oster								15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Perdw											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1950-1970		17. INFORMANT Barbara Jones Oster				ADDRESS Cumberland, MD									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>410 -</u> <u>Coronary Thrombosis, Left</u> <u>Wife</u> Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying</u> cause last. <u>Coronary Sclerosis</u> (b) <u>Coronary Sclerosis</u> (c) <u>Sudden</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE <u>Benedict Skitarellic</u>				TITLE (SPECIFY) M.D. <u>Deputy</u>				MEDICAL EXAMINER				DATE SIGNED <u>7-17-80</u>							
EXAMINER'S NAME (TYPE OR PRINT) Benedict Skitarellic, M.D.				ADDRESS R#9, Cumberland, Maryland 21502															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 7-20-80		23c. NAME OF CEMETERY OR CREMATORY Restlawn Memorial Gardens				23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD									
24. FUNERAL DIRECTOR NAME Scarpelli								ADDRESS CUMBERLAND, MD				25a. DATE REC'D. BY REGISTRAR JUL 23 1980				25b. REGISTRAR'S SIGNATURE <u>History Schudy</u>			

07-5-00 3-305

00-77-30

1. The following information is for your information only:

- 52 -

2249

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 5. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

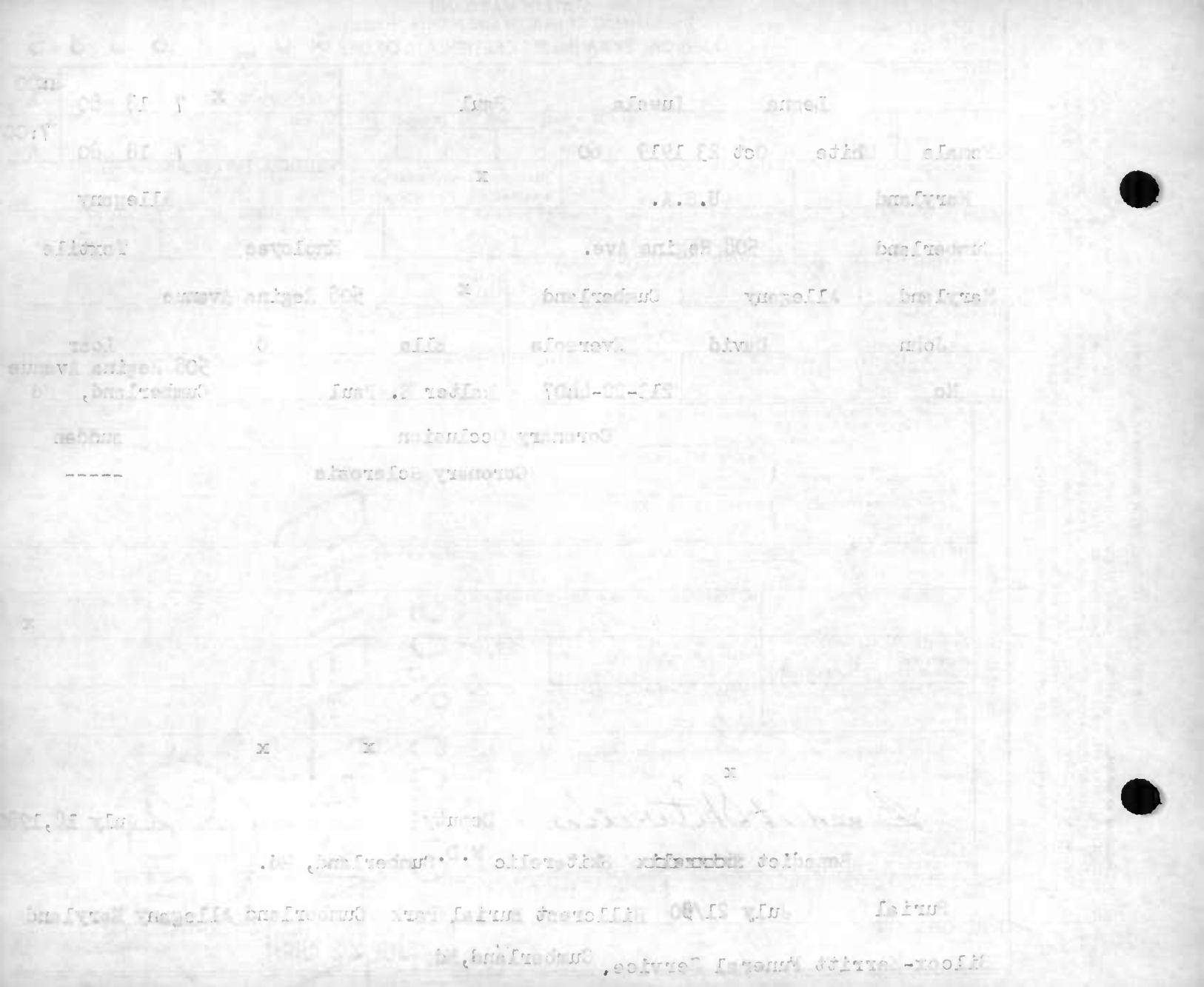
DHM - 17  
(VR A15 ME(5))  
15M 7/77

FOR  
1- STATE REGISTRAR  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 16585

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH KNOWN OF ESTI- MATED		MONTH		DAY		YEAR		2b. HOUR A M	
Leona Luwela Paul								7		18		1980				A M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		7d. HOUR A M	
Female	White	Oct 23 1919		60 YRS.				7		18		1980				A M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
Maryland		U.S.A.				Allegany MD											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Cumberland		508 Regina Ave.		Employee		Textile											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS									
Maryland		Allegany		Cumberland				508 Regina Avenue									
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
John David Eversole		Ella C Loar		No		213-22-4407		Walter E. Paul		508 Regina Avenue Cumberland, Md							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). 410- Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.		Coronary Occlusion		Coronary Sclerosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH sudden -----											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .		TITLE (SPECIFY) Deputy		DATE SIGNED July 18, 1980													
ACTUAL SIGNATURE Benedict Skitarelic		M.D. Deputy		MEDICAL EXAMINER													
EXAMINER'S NAME (TYPE OR PRINT)		Benedict Skitarelic		M.D. Cumberland, Md.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE											
Burial		July 21/80		Hillcrest Burial Park		Cumberland Allegany Maryland											
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
Silcox-Merritt Funeral Service,		Cumberland, Md		JUL 22 1980		[Signature]											





TO HOSPITAL-ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		8016586				REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
BERTHA		E		PLUM				JULY 12, 1980		4:07P M	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7a. IF UNDER 1 YEAR		7b. IF UNDER 24 HRS	
Female		White		April 18, 1903		77		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
W. Va.		U.S.A.				Allegany MD.					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN BALTIMORE CITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
CUMBERLAND, MD.		MEMORIAL HOSPITAL						Homemaker		--	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
W. Va.		Mineral		Keyser		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		42 D St.			
14. FATHER'S NAME FIRST MIDDLE LAST						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
Joseph T. Mackley						Mary J. Thomas					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17 INFORMANT ADDRESS					
No				232 74 4543		Wayne Plum 42 D St. Keyser, W. Va. 26726					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST</u> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) <u>LEFT CEREBRAL INFARCT</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ATHEROSCLEROTIC HEART DISEASE</u> Unknown										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min 6 day	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>DIABETES MELLITUS</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
				P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>7/6/1980</u> to <u>7/12/1980</u> , that (I) (we) lost saw the deceased alive on <u>7/12/1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
27b. SIGNATURE <u>[Signature]</u> MD						DEGREE		ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/>		27c. DATE SIGNED <u>7/12/80</u>	
27d. PHYSICIAN'S NAME (TYPE OR PRINT) RIAZ JANJUA, M.D.						27e. ADDRESS MEMORIAL MEDICAL BLDG., CUMB., MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial				15 July 80		Rest Lawn Mem. Gardens LaVale				Allegany Md.	
24 FUNERAL DIRECTOR NAME				24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Allen M. Rotruck				85 S. Main Keyser, W. Va.		JUL 16 1980		<u>[Signature]</u>			

0 0 0

BERTHA E PLUM JULY 10, 1900 1:07P

CUMBERLAND, MD. MEMORIAL HOSPITAL  
U.S.A. X  
Alimony  
April 15, 1903 77

M. Mrs. Winford Keyser  
J. Winford Keyser  
J. Thomas

NOT IN AGES same name as M. Mrs. Keyser, W. No. 20726

CANONICAL RECORDS

LEFT CEREBRAL INFARCT

WHEAT LEAVES BEAR DISAPPEARANCE

PLANT - FLOWERS

W. No. 20726

RIAZ JANUARY, M.D. MEMORIAL MEDICAL BLDG., CUMBERLAND, MD.

W. No. 20726

W. No. 20726

W. No. 20726

W. No. 20726

W. No. 20726

W. No. 20726

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 72 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
15M 7/77

FOR STATE REGISTRAR										STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>HAROLD R. RANDALL</b>										2a. DATE KNOWN OF DEATH MONTH DAY YEAR <b>7-9-80</b> 19 <b>10:35a</b> 2d. HOUR									
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>09-18-26</b>		6. AGE (IN YEARS) LAST BIRTHDAY YRS. <b>53</b>		IF UNDER 1 YR. MONTHS DAYS <b>0 0</b>		IF UNDER 24 HRS. HOURS MIN. <b>0 0</b>		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>7-9-80</b> 19 <b>10:35a</b> 2d. HOUR							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Ohio</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD.							
10. CITY OR TOWN OF DEATH <b>Cumberland</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Memorial Hospital----DOA</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Engineer</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>							
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>OHIO</b> 13b. COUNTY <b>Delaware</b> 13c. CITY OR TOWN <b>Delaware</b>										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS <b>7015 Duffy Road</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>George H. Randall</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lolita Moria Neuenschwander</b>													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>				16b. SOCIAL SECURITY NO. <b>300 18 9931</b>				17. INFORMANT ADDRESS <b>Connie Sue Randall Delaware, Ohio</b>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY THROMBOSIS, LEFT</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>CORONARY SCLEROSIS</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>SUDDEN</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>SUDDEN</b>																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>						TITLE (SPECIFY) <b>Deputy</b> M.D.				MEDICAL EXAMINER DATE SIGNED <b>7-9-80</b>									
EXAMINER'S NAME (TYPE OR PRINT) <b>Benedict Skitarelic, M.D.</b>						ADDRESS <b>R#9, Cumberland, Maryland 21502</b>													
23a. BURIAL, CREMATION, REMOVAL <b>Cremation</b>				23b. DATE <b>7-10-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westview Memorial Pk.</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Baltimore MD</b>									
24. FUNERAL DIRECTOR NAME <b>JAMES F. SCARPELLI</b>						ADDRESS <b>CUMBERLAND, MD</b>				25a. DATE REC'D. BY REGISTRAR <b>JUL - 5 1980</b>									
										25b. REGISTRAR'S SIGNATURE <b>John A. Brady</b>									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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(VRA 15, 4) 1/79

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR		8016588		REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) DORIS ELEANOR RANKIN			2a. DATE OF DEATH MONTH DAY YEAR JULY, 17, 1980			2b. HOUR 8:15 PM				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 20 1927		6. AGE (IN YEARS LAST BIRTHDAY) 52 YRS.		7. UNDER 1 YEAR MONTHS DAYS 7. UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Swanton		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY, MD.				
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Md.			13b. COUNTY Allegany		13c. CITY OR TOWN Westernport		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 408 Hammond St. Westernport	
14. FATHER'S NAME FIRST MIDDLE LAST John Rankin			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Rhodes							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 218-70-1878		17. INFORMANT ADDRESS Mary Rankin 408 Hammond St Westernport Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Vessel meningitis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Carcinoma of brain</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>June 17</u> 19 <u>80</u> , to <u>July 17</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>July 17</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Shine Kim</i>			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SHINE KIM, M.D.			22e. ADDRESS 90 MAIN STREET, WESTERNPORT, MARYLAND 21562							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 7/20/80		23c. NAME OF CEMETERY OR CREMATORY Philos Cem.		23d. LOCATION CITY OR TOWN COUNTY Westernport Allegany Md.			
24. FUNERAL DIRECTOR BOAL'S FUNERAL HOME			25a. DATE REC'D. BY REGISTRAR JUL 28 1980			25b. REGISTRAR'S SIGNATURE <i>Harry K. K...</i>				

8:15P

JULY 17, 1980

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Sept. 20 1982

ALBANY COUNTY

Swanton

SACRED HEART HOSPITAL

Colfax, Ind

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80 MAIN STREET, WESTPORT, MARYLAND 21552

PAINE KIM, M.D.

John

1/25/80

John

JUL 28 1980

BOAL'S PATRIAL HOME, BROMLEY, W.VA. 26105



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		8 0 1 6 5 8 9	
1. DECEASED NAME (TYPE OR PRINT) <b>JOHN WILLIAM RAUPACH, SR.</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>JULY 30, 1980</b>		2b. HOUR <b>7:45A</b>	
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Aug. 15, 1915</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>64</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD.	
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>MEMORIAL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Mold Changer,</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Kelly Tire Co.</b>
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Allegany</b>	13c. CITY OR TOWN <b>Cumberland,</b>	13d. STREET ADDRESS <b>886 Sperry Terrace,</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Albert Milton Raupach</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Leah Viola Leytig</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes,</b>		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATA) <b>W. W. # 2 814-07-2610</b>		17. INFORMANT ADDRESS <b>Cumberland, Md. Mrs. Twila H. Raupach, 886 Sperry Terrace,</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma</b> <b>1541</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Carcinoma rectum</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b> <b>18 months.</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>Deficient peripheral circulation</b>					
19a. DATE OF OPERATION <b>29</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Small bowel obstruction</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>1979</b> , 19____, to <b>July 29</b> , 19 <b>80</b> , that (I) (we) lost saw the deceased alive on <b>29 July</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Carlton Brinsfield</b>		DEGREE		22c. DATE SIGNED <b>7-30-80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. CARLTON BRINSFIELD</b>		22e. ADDRESS <b>401 DECATUR STREET CUMBERLAND, MD. 21502</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>8/1/80</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park,</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cumberland, Allegany Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>H. Wayne George</b>		25a. DATE <b>21502</b>		25b. REGISTRAR'S SIGNATURE <b>Aug 1 1980</b>	
25c. ADDRESS <b>202 Greene St. Cumberland, Md.</b>					

401 DECATUR STREET  
CAMBERLAND, ME. 04102

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1 - FOR  
STATE  
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>Maude</b>		FIRST <b>E.</b>		MIDDLE <b>Rice</b>		LAST <b>Rice</b>		2a DATE OF DEATH <b>7/25/80</b>		MONTH <b>7</b>		YEAR <b>80</b>		2b HOUR <b>4:00</b>			
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH <b>Jan.</b> DAY <b>30</b> YEAR <b>1888</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>92</b>		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>							
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD											
10 CITY OR TOWN OF DEATH <b>Cumberland</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>The Allegany County Infirmary</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>				12b KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																	
13a STATE <b>Maryland</b>		13b COUNTY <b>Allegany</b>		13c CITY OR TOWN <b>Cumberland</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <b>636 Fairview Avenue</b>									
14 FATHER'S NAME FIRST <b>Samuel</b> MIDDLE <b>E.</b> LAST <b>Kauffman</b>								15 MOTHER'S MAIDEN NAME FIRST <b>Florence</b> MIDDLE <b>R.</b> LAST <b>Cummsford</b>									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b SOCIAL SECURITY NO. <b>217-48-3611</b>		17 INFORMANT ADDRESS <b>Edwin J. Rice, Cumberland, Maryland</b>													
18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute coronary occlusion</b> DUE TO, OR AS A CONSEQUENCE OF: Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>coronary sclerosis</b> DUE TO, OR AS A CONSEQUENCE OF: (c) <b></b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>years</b>																	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <b>Chronic Organic Brain Syndrome Nutritional Deficiency Ch. Heart Failure</b>																	
19a DATE OF OPERATION <b>7-25</b>		19b CONDITION FOR WHICH OPERATION WAS PERFORMED <b>coronary artery bypass graft</b>				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)													
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE													
22a I certify that (I) (this hospital) attended the deceased from <b>7-25</b> <b>1980</b> , to <b>7-25</b> <b>1980</b> , that (I) (we) last saw the deceased alive on <b>7-25</b> <b>1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b SIGNATURE <b>John A. Taffer</b>										DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <b>7-26-80</b>			
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>John A. Taffer</b>										22e ADDRESS <b>Henderson, Ga</b>							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b DATE <b>July 28, 80</b>		23c NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial E. Cumberland - Allegany, Md</b>				23d LOCATION CITY OR TOWN COUNTY STATE									
24 FUNERAL DIRECTOR NAME: <b>William G. Right</b> ADDRESS: <b>Cumberland, Maryland</b>																	
25a DATE REC'D. BY REGISTRAR <b>AUG 1 1980</b> 25b REGISTRAR'S SIGNATURE <b>[Signature]</b>																	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 1 6 5 9 1 REG. NO.			
1. FOR - STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RITA H. RILLING				JULY 20, 1980			
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jul. 26, 1890		6 AGE (IN YEARS LAST BIRTHDAY) 89 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. Y.		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.	
10 CITY OR TOWN OF DEATH CUMBERLAND, MD.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Md.		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Hugh P. Holahan		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Josephine Gay		13e. STREET ADDRESS Rt. # 3, Bedford Rd.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 215-20-7032		17 INFORMANT ADDRESS Mrs. Robert Johnston, Covington, LA			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebrovascular accident 436- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Pneumonia, hypotensive							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 7-30 7-30 1980, to 7-20 7-20 1980, that (I) (we) lost saw the deceased alive on above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Robustiano J. Barrera, MD				DEGREE MD		22c. DATE SIGNED 7-25-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. ROBUSTIANO J. BARRERA				22e. ADDRESS MEMORIAL HOSPITAL MEDICAL BLDG. CUMBERLAND, MARYLAND 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jul. 22, 1980		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Con		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD	
24 FUNERAL DIRECTOR NAME William G. Kight Cumberland, MD				25a. DATE REC'D. BY REGISTRAR JUL 31 1980		25b. REGISTRAR'S SIGNATURE [Signature]	

BP

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JULY 20, 1980 2:00P

RITA H. PILLING



CUMBERLAND, MD. MEMORIAL HOSPITAL

MEMORIAL HOSPITAL MEDICAL BLDG.  
CUMBERLAND, MARYLAND 21502

DR. ROBERTO J. BARRERA

JUL 21 1980



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8016592	
1. FOR STATE REGISTRAR					REG. NO.						
1 DECEASED NAME (TYPE OR PRINT) <b>LAWRENCE PAUL ROBERTSON</b>					2a DATE OF DEATH MONTH DAY YEAR <b>JULY 13, 1980</b>				2b HOUR <b>8:35AM</b>		
3 SEX <b>MALE</b>		4 RACE <b>WHITE</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>Jan. 8, 1908</b>		6 AGE (IN YEARS (LAST BIRTHDAY)) <b>71 YRS.</b>		7 UNDER 1 YEAR MONTHS DAYS <b>71</b>		7 UNDER 24 HRS. HOURS MIN. <b>71</b>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD.					
10 CITY OR TOWN OF DEATH <b>CUMBERLAND</b>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MEMORIAL HOSPITAL</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>			12b KIND OF BUSINESS OR INDUSTRY <b>B. &amp; O. RR</b>		
13a STATE <b>W. Va.</b>			13b COUNTY <b>MORGAN</b>		13c CITY OR TOWN <b>PAW PAW</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <b>Winchester Ave.</b>		
14 FATHER'S NAME FIRST MIDDLE LAST <b>Harrison D. Robertson</b>					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Laura Gracey</b>						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>			16b SOCIAL SECURITY NO. <b>W.W. #2 232-10-2520</b>		17 INFORMANT ADDRESS <b>Mrs Pearl Robertson, Paw Paw, W.Va.25434</b>						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARDIO-PULMONARY ARREST</b> <b>410-</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ACUTE MYOCARDIAL INFARCTION - 1 WEEK</b> (c) <b>COMA - POST ARREST.</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE						
22a I certify that (I) (this hospital) attended the deceased from <b>6/28</b> , 19 <b>80</b> , to <b>13 JULY 80</b> , that (I) (we) lost saw the deceased pass away above, (I) (we) did (did not) view the body after death.											
22b SIGNATURE <b>[Signature]</b>					DEGREE			22c DATE SIGNED <b>7/16/80</b>			
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. RAVEN</b>					22e ADDRESS <b>MEMORIAL HOSPITAL MED. BLDG., CUMBERLAND, MD. 21502</b>						
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b DATE <b>7/15/1980</b>		23c NAME OF CEMETERY OR CREMATORY <b>Woodrow Cemetery</b>			23d LOCATION CITY OR TOWN COUNTY STATE <b>Paw Paw, (Morgan) w.va25434</b>			
24 FUNERAL DIRECTOR <b>JOHNSON F. Home</b>					25a DATE REC'D. BY REGISTRAR <b>11 JUL ~ 4 1980</b>			25b REGISTRAR'S SIGNATURE <b>[Signature]</b>			



8:35A

JULY 17, 1980

LAWRENCE PAUL ROBERTSON

CUMBERLAND MEMORIAL HOSPITAL

DR. RAY

CUMBERLAND, MD. 21202  
MEMORIAL HOSPITAL MED. BLDG.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17  
(VR A15 ME (5))  
15M/7/77

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 16593

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Cobey</b>		FIRST <b>(Coby)</b>		MIDDLE <b>Joseph</b>		LAST <b>Robinson</b>		2b. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTI-MATED <input type="checkbox"/> <b>7-18-80</b>		MONTH <b>19</b>		DAY <b>8</b>		YEAR <b>1980</b>		2d. HOUR <b>33p</b>					
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>05-23-75</b>		6. AGE (IN YEARS) <b>5</b> YRS.		IF UNDER 1 YR. MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>		2c. DATE PRONOUNCED DEAD <b>7-18-80</b>		MONTH <b>19</b>		DAY <b>8</b>		YEAR <b>1980</b>		2d. HOUR <b>33p</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b>									
10. CITY OR TOWN OF DEATH <b>Cumberland</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Memorial Hospital----DOA</b>								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY					

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. STATE <b>Maryland</b>				13b. COUNTY <b>Allegany</b>				13c. CITY OR TOWN <b>Oldtown, Md.</b>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS <b>RD#1 Box 186</b>			
14. FATHER'S NAME FIRST <b>Lawrence</b> MIDDLE <b>Robinson</b> LAST <b></b>								15. MOTHER'S MAIDEN NAME FIRST <b>Genevieve</b> MIDDLE <b>Knowles</b> LAST <b></b>															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b>								16b. SOCIAL SECURITY NO.								17. INFORMANT ADDRESS <b>Mr. Lawrence Robinson, Oldtown, Md. Father</b>							

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY:																	
IMMEDIATE CAUSE (a) <b>Asphyxiation</b>																<b>Minutes</b>	
DUE TO, OR AS A CONSEQUENCE OF																	
(b) <b>Drowning</b>																<b>"</b>	
DUE TO, OR AS A CONSEQUENCE OF																	
(c) <b>(accidental)</b>																	

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b>7:15 P.M. 7-18-80</b>				21b. TIME OF INJURY HOUR <b>7:15</b> MONTH <b>7</b> DAY <b>18</b> YEAR <b>1980</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Drowned in farm Pond</b>							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Farm Pond</b>				21f. LOCATION STREET <b>Oldtown Road near Millstone</b> CITY OR TOWN <b>Allegany</b> COUNTY <b>Md.</b> STATE <b></b>							

22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>								TITLE (SPECIFY) <b>Deputy</b>				DATE SIGNED <b>7-18-80</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Benedict Skitarelic, M.D.</b>								ADDRESS <b>R#9, Cumberland, Maryland 21502</b>							

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>7-21-1980</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Tabor Cemetery</b>				23d. LOCATION CITY OR TOWN <b>Oldtown</b> COUNTY <b>Allegany</b> STATE <b>Md.</b>			
---	--	--	--	----------------------------	--	--	--	--	--	--	--	---	--	--	--

24. FUNERAL DIRECTOR NAME <b>Scarpelli James F.</b> ADDRESS <b>Scarpelli, Cumberland</b>								25a. DATE REC'D. BY REGISTRAR <b>JUL 23 1980</b>				25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			
--	--	--	--	--	--	--	--	--	--	--	--	---	--	--	--



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. FOR PAGE 4, SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

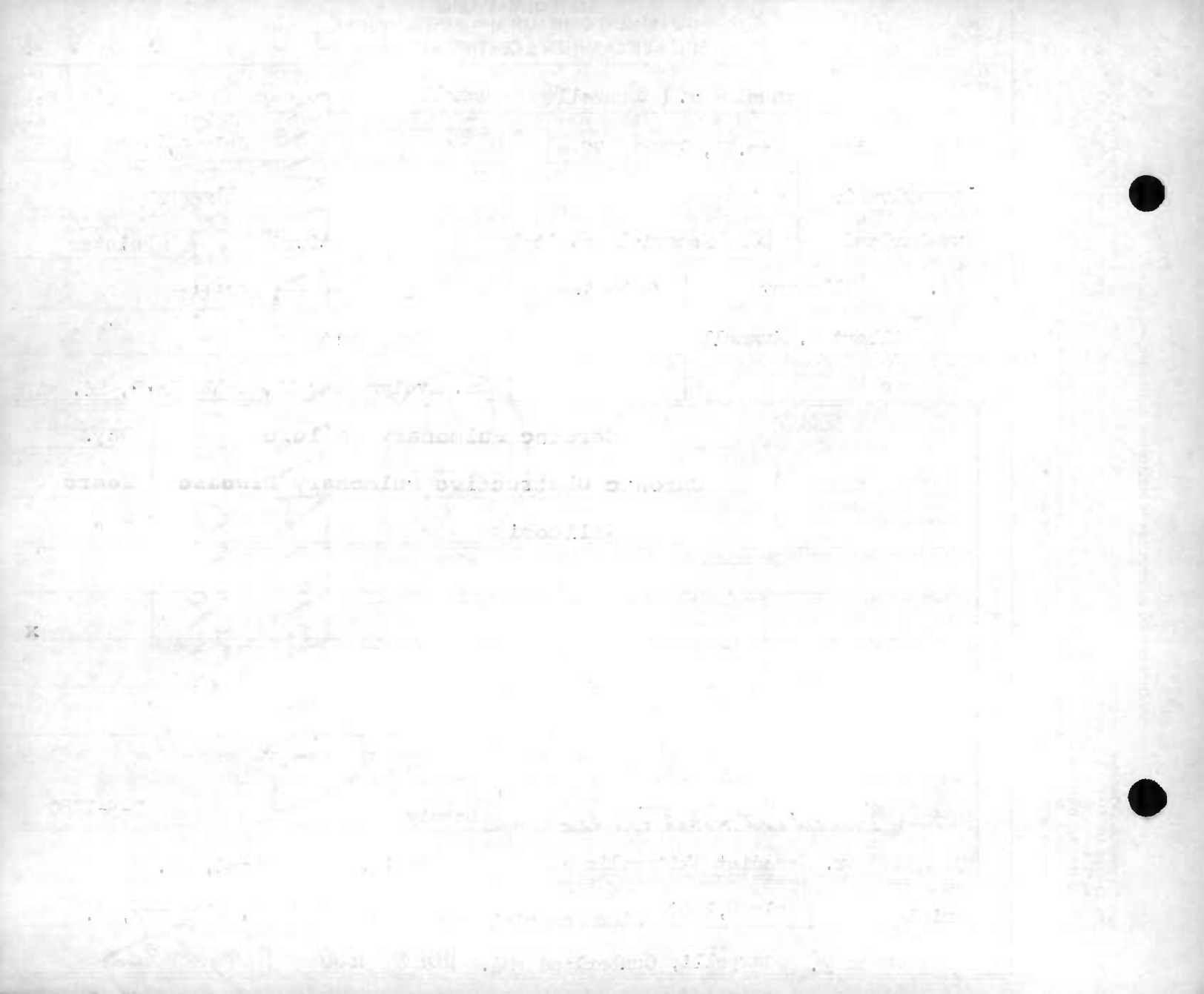
BP

DMMH - 17  
(VR A15 ME (5))  
30M 7/73

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 1 6 5 9 4

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE KNOWN OF DEATH		2b. HOUR	
FIRST MIDDLE LAST		MONTH DAY YEAR		HOUR	
Samuel S. (Rummell) Rummell		7-3 19 80		8:am	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.
Male	White	Jan. 29, 1908	72 YRS.	MONTHS DAYS	HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED	NEVER MARRIED		
Pennsylvania	USA	WIDOWED	DIVORCED		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION	9. BALTIMORE CITY OR COUNTY OF DEATH			
Cumberland	DOA Memorial Hospital	Allegany MD.			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY				
Retired	Painter				
13a. STATE	13b. CITY OR TOWN	13c. INSIDE CITY LIMITS?	13d. STREET ADDRESS		
Md.	Allegany	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	Bowmans Addition		
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME				
FIRST MIDDLE LAST	FIRST MIDDLE LAST				
Albert B. Rummell	Rose Smith				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS			
no		Mrs. Evelyn Rummell, Cumberland, Md. Wife			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Cardiac Pulmonary Failure					Days
502- DUE TO, OR AS A CONSEQUENCE OF					
(b) Chronic Obstructive Pulmonary Disease					Years
DUE TO, OR AS A CONSEQUENCE OF					
(c) Silicosis					"
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
		HOUR A.M. MONTH DAY YEAR			
		P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION	
				STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED	
Benedict Skitarelic		Deputy		7-5-1980	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS			
Dr. Benedict Skitarelic MD		Cumberland, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION		
Burial	July 7, 1980	Zion Memorial Park	Cumberland, Allegany, Md.		
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
NAME ADDRESS		JUL 8 1980		P. F. Scarpelli	
James F. Scarpelli, Cumberland Md.					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		7 0		1 6 5 9 5		REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
Regina		M		Schaaf				7/22/80		1:35 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		White		MONTH DAY YEAR 2 11 94		86 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Cumberland, Md		USA				Allegany MD					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Frostburg, Md.		Frostburg Community Hospital						Housewife			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS			
Md		Allegany		Frostburg				1 Kaylor Circle			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
FRANK		KIENHOFFER		MARIAN PAULUS							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS					
NO		214-05-4790		J Mallory		48 Tarn Terrace, Frostburg,					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CVA Cerebral Thrombosis</u> <u>4029</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CBS with Generalized Arteriosclerosis</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>											
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF INJURY, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>July 16, 1980</u> to <u>July 22, 1980</u> , that (I) (we) lost saw the deceased alive on <u>July 22, 1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Charles J. Syme Jr. M.D.</u>		DEGREE		22c. DATE SIGNED <u>7/22/80</u>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
BURIAL		JULY 25, 1980		SS. PETER & PAUL CEM		CUMBERLAND ALLEGANY MD					
24. FUNERAL DIRECTOR NAME ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
LEASURE-STEIN FUNERAL HOME, INC.		230 BALTIMORE AVE		JUL 30 1980							

BP



1000 1000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8016596			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>EDITH JOSEPHINE SCHADE</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>JULY 31, 1980</b>			
3 SEX <b>Female</b>				2b. HOUR <b>6:15 P.M.</b>			
4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>Dec. 10, 1920</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD.	
10 CITY OR TOWN OF DEATH <b>CUMBERLAND, MD.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MEMORIAL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13a. STATE <b>Md.</b>		13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Cumberland</b>		13d. STREET ADDRESS <b>510 Marshall St.</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Frank Riley</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Caroline Zilch</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>214-46-3726</b>		17. INFORMANT ADDRESS <b>Mrs. Ruth Chapman Rt. #3 Box 135E Cumb., Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial infarction</b>							
2028 CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (b) <b>Myocardial infarction</b>							
DUE TO, OR AS A CONSEQUENCE OF (c) <b>Myocardial infarction</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>7/31/80</b> to <b>7/31/80</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If not, state date and hour and from the causes stated.)							
22b. SIGNATURE <b>W. Guy Fiscus</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>8/3/80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. W. GUY FISCUS</b>				22e. ADDRESS <b>MEMORIAL HOSPITAL MEDICAL BLDG. CUMBERLAND, MD. 21502</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Aug 3, 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Lukes Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cumberland Allegany Md.</b>	
24 FUNERAL DIRECTOR NAME <b>Silcox-Merritt Fun. Ser. Cumberland Md.</b>				25. DATE REC'D. BY REGISTRAR <b>AUG 6 1980</b>		26. REGISTRAR'S SIGNATURE	

0 0 0 0

MEMORIAL HOSPITAL

EDITH JOSEPHINE SCHADE JULY 31, 1980 6:15P

White Female U.S.A. 100

CUNBERLAND, MD. MEMORIAL HOSPITAL

Admission to hospital

Chief Complaint

History of Present Illness

*Handwritten notes in cursive script, mostly illegible.*

*Handwritten signature or initials.*

*Handwritten notes and dates, including "8/1/80" and "8/2/80".*

MEMORIAL HOSPITAL MEDICAL BLDG. CUNBERLAND, MD. 21502

DR. W. J. FISHER

Physician

AUG 2 1980

*Handwritten notes at the bottom of the page.*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8016597 REG. NO.			
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
		PHOEBIE NMI SCHRAMM		JULY 6, 1980		4:22A <sub>M</sub>	
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)	
FEMALE		WHITE		DEC. 23, 1902		77 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Maryland		U.S.A.				ALLEGANY COUNTY, MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
CUMBERLAND		SACRED HEART HOSPITAL		OWNER-OPERATOR		MOTEL-RESTAU.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13b. INSIDE CITY LIMITS?		13c. STREET ADDRESS	
13a. STATE MARYLAND 13b. COUNTY ALLEGANY 13c. CITY OR TOWN FROSTBURG				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		RT. 2, BOX 630	
14. FATHER'S NAME MIDDLE LAST				15. MOTHER'S MAIDEN NAME MIDDLE LAST			
JOHN GLENN				MARGARET WATKINSON			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO				219-56-9204		FROSTBURG, MD. MR. CHARLES SCHRAMM, RT. 2, BOX 630.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Coronary heart failure</u> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic coronary HD</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>Diabetes, Renal insufficiency</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
30 June 1980		Rash gain Dissection		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 19 <u>08</u> to <u>6 July</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>5 July</u> 19 <u>80</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
<u>Frederick Miltenberger</u>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		<u>7 July 80</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
FREDERICK MILTENBERGER, M.D.				112 S. CENTRE STREET, CUMBERLAND, MD 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
BURIAL		7/9/80		FROSTBURG MEM. PK.		FROSTBURG, ALLEGANY, MD.	
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE RECD. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
<u>Marion M. Sowers</u>		60 W. MAIN ST. FROSTBURG, MD 21532		<u>JUL 11 1980</u>		<u>1-7</u>	

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PHOTOGRAPHED JULY 1938

U.S.A. MARYLAND

JOHN H. HARRIS

1910-1911

110 S. CENTRE STREET, BALTIMORE, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	0	1	6	5	9	8		
FOR 1 - STATE REGISTRAR										CERTIFICATE OF DEATH								
1. DECEASED NAME (TYPE OR PRINT)										2a. DATE OF DEATH				2b. HOUR				
FANNIE *NMI* SHAFFER										JULY 5, 1980				10:00P <sub>M</sub>				
3 SEX			4 RACE			5 DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)			7 UNDER 1 YEAR		7 UNDER 24 HRS				
Female			White			October 19, 1886			93 YRS.			MONTHS DAYS		HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH									
West Virginia			USA						ALLEGANY COUNTY, MD.									
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Cumberland			SACRED HEART HOSPITAL							Housewife			Home					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS					
13a. STATE 13b. COUNTY 13c. CITY OR TOWN										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			None					
14. FATHER'S NAME FIRST MIDDLE LAST										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST								
Lewis ----- Ewing										Mollie ----- (Unknown)								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17 INFORMANT ADDRESS												
No			232-82-0092			Clifton Shaffer, Cumberland, Md. 21502												
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 Congestive Heart Failure										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD																		
DUE TO, OR AS A CONSEQUENCE OF (c)																		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Asystole																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)												
			P.M. 19															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE												
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																		
22b. SIGNATURE										DEGREE			22c. DATE SIGNED					
Victor E. Mazzocco, MD										ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			7-11-80					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										22e. ADDRESS								
Victor E. Mazzocco, MD										BMG-912 SETON DRIVE, CUMBERLAND, MD. 21502								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE									
burial			7/8/80			Aurora Cemetery			Aurora, Preston, West Virginia									
24 FUNERAL DIRECTOR NAME										24b. ADDRESS			25a. DATE RECEIVED BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Bradley A. Stewart										32 ND. STREET OAKLAND, MD.			JUL 10 1980					
STEWART FUNERAL HOME																		

10:00 PM MAY 2, 1902 CHAPTER

WILLIAM COOPER

SACRED HEART HOSPITAL

St. Louis, Mo.  
May 2, 1902

10-012 Street, St. Louis, Mo. 21502

ST. LOUIS, MO. MAY 2, 1902

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 retained by the hospital or attending physician.

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DHMH - 16 60M 1/75  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 1 6 5 9 9

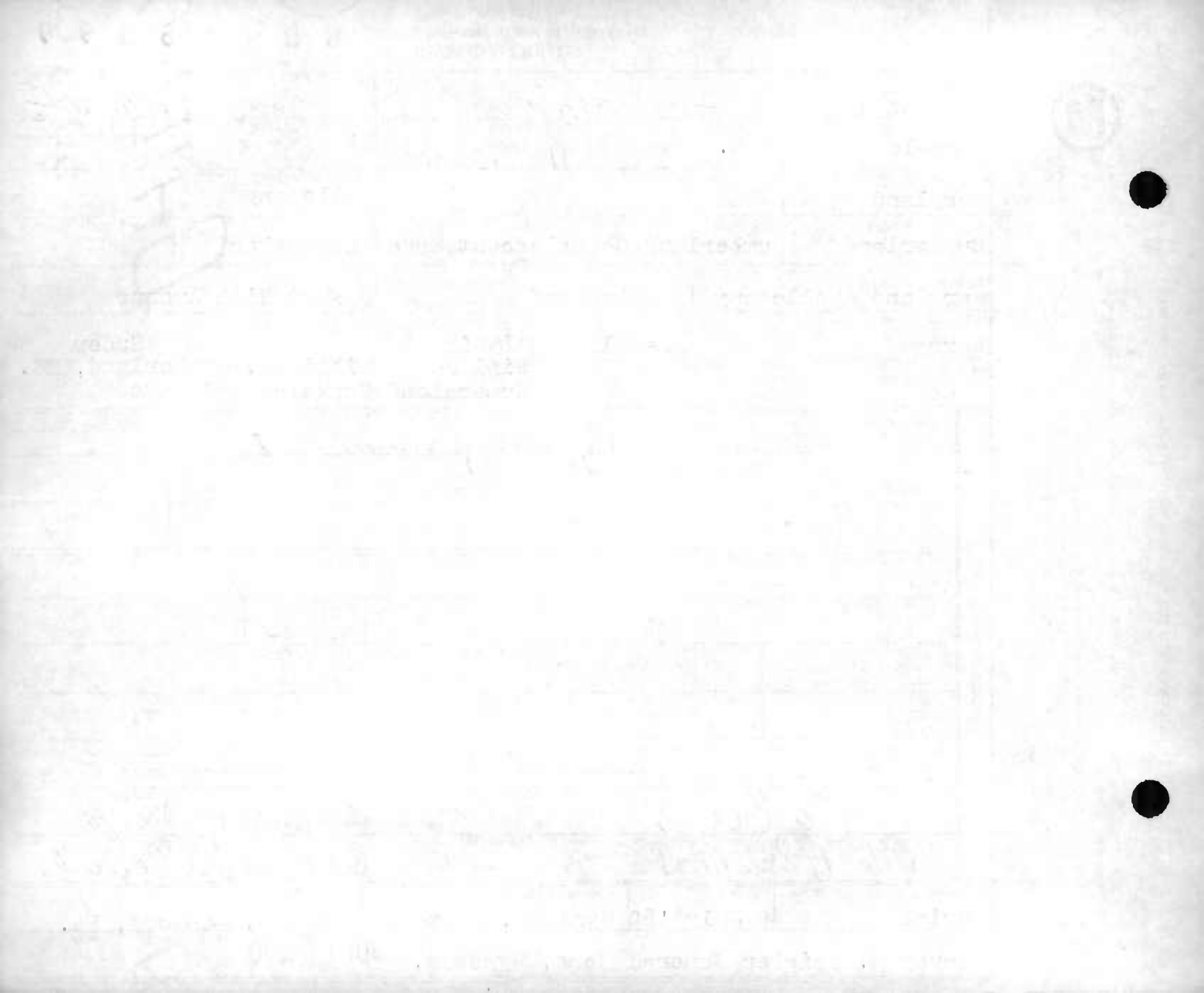
FOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Sue A Shaffer</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>July 5 1980</b>			2b. HOUR <b>10 15 PM</b>			
3. SEX <b>Female</b>		4. RACE <b>Cau.</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11-13-98</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b>		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD.			
10. CITY OR TOWN OF DEATH <b>Cumberland</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Cumberland Convalescent Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Cumberland</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>8 Fort Hill Avenue</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Harry Merkle</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lydia Suder</b>			16. DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>			
16a. SOCIAL SECURITY NO. <b>Winfred &amp; Williams, Cumberland, Md.</b>			16b. SOCIAL SECURITY NO. <b>Cumeraland Convalescent Home</b>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last (b) <b>514-</b> DUE TO, OR AS A CONSEQUENCE OF (c)			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Shaffer</b>				DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>7/5/80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>V.B. HAZZARD</b>				22e. ADDRESS <b>302 Schlegel St. Cumberland.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9 July '80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hyndman Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hyndman, Bedford, Pa.</b>		23e. DATE RECEIVED BY REGISTRAR <b>JUL 15 1980</b>	
24. FUNERAL DIRECTOR NAME <b>Harvey H. Zeigler Funeral Home, Hyndman,</b>				ADDRESS <b>Harvey H. Zeigler Funeral Home, Hyndman,</b>		25a. DATE RECEIVED BY REGISTRAR <b>JUL 15 1980</b>			
25b. REGISTRAR'S SIGNATURE <b>Harvey H. Zeigler</b>									

MEDICAL CERTIFICATION





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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 1 6 6 0 0			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Clarence C. Sharpless				2a. DATE OF DEATH MONTH DAY YEAR 07 13 80		2b. HOUR 9:50 PM	
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 05 10 07		6 AGE (IN YEARS LAST BIRTHDAY) 73 YRS # UNDER 1 YEAR MONTHS DAYS # UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Allegany County MD.	
10 CITY OR TOWN OF DEATH Frostburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frostburg Community Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Miner		12b. KIND OF BUSINESS OR INDUSTRY Coal	
13a. STATE Maryland				13b. COUNTY Garr.		13c. CITY OR TOWN Mt. Lake	
14 FATHER'S NAME FIRST MIDDLE LAST John Luther Sharpless				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Mae Harvey			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Unknown No		16b. SOCIAL SECURITY NO. 213-01-6617		17 INFORMANT Kelly Carter Frostburg Community Hospital			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> 410 - DUE TO, OR AS A CONSEQUENCE OF (b) <u>acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>C.H.F. AS CV.D.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Osteoarthritis, osteoarthritis</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>July 7</u> , 19 <u>80</u> , to <u>July 13</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>July 13</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Shin E. Kim</u>				DEGREE M.D.		22c. DATE SIGNED 7/13/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Shin E. Kim, M.D.				22e. ADDRESS 48 Tarn Terrace, Frostburg, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/16/80		23c. NAME OF CEMETERY OR CREMATORY Oakland Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Oakland Garr., Md.	
24 FUNERAL DIRECTOR NAME Durst Funeral Home, Oakland, Md.				25a. DATE RECEIVED BY REGISTRAR JUL 16 1980		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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## MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		8 0 1 6 6 0 1	
1. DECEASED NAME (TYPE OR PRINT) <b>EDNA C. SIEFERS</b>		2a. DATE OF DEATH <b>JULY 9, 1980</b>		2b. HOUR <b>1:15P<sup>M</sup></b>	
3 SEX <b>Female</b>	4 RACE <b>White</b>	5 DATE OF BIRTH <b>Sept. 5, 1893</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>86</b> YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b CITIZEN OF WHAT COUNTRY? <b>USA</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD	
10 CITY OR TOWN OF DEATH <b>CUMBERLAND</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MEMORIAL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK OR BUSINESS OR WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>
13a. STATE <b>MD</b>		13b. COUNTY <b>Allegany</b>	13c. CITY OR TOWN <b>Cumberland</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME <b>Frederick Herbich</b>		15. MOTHER'S MAIDEN NAME <b>Randy Rice</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Pauline Howdysshell Cumberland, MD Daughter</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic respiratory arrest</b> <b>4292</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CITF</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) <b>ASCVD</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>immediate</b> <b>yes</b> <b>yes</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>4/24</b> 19 <b>80</b> , to <b>7/9</b> 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>7/8/80</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.					
22b. SIGNATURE <b>Dr. Anthony J. Bollino, Jr.</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>9 Aug 80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. ANTHONY J. BOLLINO, JR.</b>		22e. ADDRESS <b>955 FREDRICK STREET CUMBERLAND, MD. 21502</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>7-12-80</b>	23c. NAME OF CEMETERY OR CREMATORY <b>SS. Peter and Paul Church, Cumberland, Allegany, MD</b>		23d. LOCATION CITY OR TOWN COUNTY STATE	
24 FUNERAL DIRECTOR NAME <b>JAMES F. SCARPELLI</b>		ADDRESS <b>CUMBERLAND, MD</b>		25a. DATE REC'D. BY REGISTRAR <b>9/10/80</b>	
				25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

1582

EDNA C. SIEFFERS JULY 9, 1980 1:15P

CUMBERLAND MEMORIAL HOSPITAL

4220  
 11-9  
 11-9

0 08 P/R 05 0 05/14 00/14 0 0 0

955 FREDRICK STREET  
CUMBERLAND, MD. 21502

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		8 0 1 6 6 0 2		REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
JOSEPHINE BENEDICT SPIKER				JULY 30, 1980				12:05 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
FEMALE		WHITE		8 MONTH DAY YEAR 8 21 1877		102 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
MARYLAND		U S A				ALLEGANY COUNTY, MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
CUMBERLAND		SACRED HEART HOSPITAL		SEAMSTRESS		FASHION			
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
MARYLAND				ALLEGANY		CUMBERLAND		YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME					
FIRST MIDDLE LAST ROBERT SPIKER				FIRST MIDDLE LAST MARY COLEMAN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO		17. INFORMANT ADDRESS			
NO				214-46-3746T		URSULA BRODE, CUMBERLAND, MD. 21502			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Gram negative sepsis</u> <u>1536</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Suspected carcinoma - right colon</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cerebrovascular accident</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>months</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>Cerebrovascular accident</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>7-22</u> 19 <u>80</u> , to <u>7-30</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>7-30</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Thomas Devlin</u>				DEGREE MD				22c. DATE SIGNED 7-31-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
THOMAS DEVLIN, M.D.				55 JACKSON STREET, LONACONING, MD. 21539					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
BURIAL		1-2-1980		SS. PETER & PAUL CEMETERY		CUMBERLAND ALLEGANY MD			
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		24c. DATE REC'D. BY REGISTRAR		24d. REGISTRAR'S SIGNATURE			
LEASURE-STEIN		230 BALTIMORE AVE CUMBERLAND, MD.		AUG 6 1980		<u>[Signature]</u>			

BP





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		8 0 1 6 6 0 3		REG. NO.							
1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH MONTH DAY YEAR			2b HOUR A.M.		
Joseph Berkley Stafford						07 22 80			5:30 A.M.		
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		7 UNDER 1 YEAR MONTHS DAYS		7 UNDER 24 HRS HOURS MIN.	
Male		Caucasian		05 20 96		84 YRS					
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		USA				Allegany MD.					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY		
Cumberland		Lions Manor Nursing Home				Farmer, Ret'd			Farming,		
13a STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS		
Maryland			Allegany		Cumberland		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Route #4, Box 425		
14 FATHER'S NAME FIRST MIDDLE LAST			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST								
George M. Stafford			Martha L. Bucy								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO.			17 INFORMANT ADDRESS					
No.			215-20-7219			Lions Manor Nursing Home, Cumberland, MD					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). 410 - Acute coronary occlusion										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic arteriosclerotic Heart Disease years										Minutes	
(c) Coronary Sclerosis years										Years	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (11a) Chronic Lymphogenous Leukemia											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from June 12, 1979, to July 22, 1980, that (I) (we) last saw the deceased alive on July 22, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE John A. Topper						DEGREE M.D.		22c DATE SIGNED 7 22 80			
22d PHYSICIAN'S NAME (TYPE OR PRINT) John A. Topper, M.D.						22e ADDRESS Lions Manor Nursing Home, Cumb., MD					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE 7/25/80		23c NAME OF CEMETERY OR CREMATORY Sunset Memorial Park,			23d LOCATION CITY OR TOWN COUNTY STATE Cumberland, Allegany Maryland			
24 FUNERAL DIRECTOR NAME H. Wayne George 202 Greene St. Cumberland, Md.						24b ADDRESS 21502		25a DATE REC'D. BY REGISTRAR JUL 20 1980		25b REGISTRAR'S SIGNATURE	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 1 6 6 0 4			
1. FOR STATE REGISTRAR				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ALFRED JOSEPH STONEY				2a DATE OF DEATH MONTH DAY YEAR 7-29-80		2b HOUR 8:30A	
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Nov. 23, 1916		6 AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 63	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Massachusetts		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.	
10 CITY OR TOWN OF DEATH CUMBERLAND		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Office Manager		12b KIND OF BUSINESS OR INDUSTRY Store	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b STATE Maryland		13c COUNTY Allegany		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 12 South Lee Street	
14 FATHER'S NAME FIRST MIDDLE LAST Henry H. Stoney		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gertrude McCarthy					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII 022-01-4098		17 INFORMANT ADDRESS Eleanor R. Stoney, Cumberland, Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Esophagus</u> 1509 (b) <u>Widespread metastases</u> DUE TO OR AS A CONSEQUENCE OF (c) <u></u> DUE TO OR AS A CONSEQUENCE OF (d) <u></u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <u>7/28/80</u> to <u>7/29/80</u> , that (I) (we) lost saw the deceased alive or above (I) (we) (did) (did not) view the body after death. 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated							
22b SIGNATURE <u>W. B. Barrera</u> DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c DATE SIGNED <u>7/30/80</u>			
22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>BARRERA</u>				22e ADDRESS <u>MEMORIAL MEDICAL BUILDING CUMB. MD.</u>			
23a BURIAL, CREMATION, REMOVAL SPECIFY Burial		23b DATE Aug. 1, 80		23c NAME OF CEMETERY OR CREMATORY Hutson Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Rawlings Allegany MD.	
24 FUNERAL DIRECTOR NAME William G. Kight				24b ADDRESS Cumberland, Maryland		25 DATE REC'D. BY REGISTRAR AUG 7 1980	
				25b REGISTRAR'S SIGNATURE <u>History McNeely</u>			

ALFRED JOSEPH STONEY 7-22-88 8:10A

CUMBERLAND MEMORIAL HOSPITAL

*Handwritten signature*

CUMBERLAND MEMORIAL HOSPITAL BUILDING CUMBERLAND, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DHMH-16 25M  
(VRA 15, 4) 1/79

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8016605			
1. FOR STATE REGISTRAR		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
MARSHALL		C.		TWIGG		JULY 10, 1980		1440P				M	
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male		Whitee		Nov. 5, 1892		87		MONTHS		DAYS		HOURS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland		USA				Allegany						MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
CUMBERLAND		MEMORIAL HOSPITAL		Retired		Retail							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. COUNTY		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS					
Maryland		Allegany		Cumberland		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		520 Pearre Ave.					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
First		Middle		Last		First		Middle		Last			
Oliver		Twigg		Unknown									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS							
No		814-05-8320		Marshall S. Twigg, Cumberland, Md.									
18. CAUSE OF DEATH (Enter only one cause and list the immediate cause)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 1. DEATH WAS CAUSED BY													
IMMEDIATE CAUSE (a)													
4149													
DUE TO													
Advanced, with death CHF, CAD													
DUE TO													
ASCD, DM													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK													
22a. I certify that (I) (this hospital) attended the deceased from July 9, 1980, to July 10, 1980, that (I) (we) lost saw the deceased alive on July 9, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. DEGREE MD		22c. DATE SIGNED 7-11-80									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
DR. T. WILLIAMS		MEMORIAL HOSPITAL MEDICAL BUILDING, CUMBERLAND, MD 21502											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE							
Burial		July 12, 80		St. Luke's Cemetery		Cumberland, Allegany, Md.							
24. FUNERAL DIRECTOR NAME		24b. DATE REC'D. BY REGISTRAR		24c. REGISTRAR'S SIGNATURE									
William Knight, Cumberland, Maryland		JUL 14 1980											

14409

JULY 10, 1980

TWIGG

C.

MARSHALL

MEMORIAL HOSPITAL

CUMBERLAND

Admitted 7/10/80  
Admission # 14409  
CUMBERLAND MEMORIAL HOSPITAL

Admitted 7/10/80  
Admission # 14409

DR. T. WILLIAMS

MEMORIAL HOSPITAL  
MEDICAL BUILDING, CUMBERLAND, MD 21502

JUL 14 1980

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**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH**

8 0 1 6 6 0 6

1- FOR  
 STATE  
 REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>PHYLLIS HIDA TWIGG</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JULY 17, 1980</b>			2b. HOUR <b>4:10P<sup>M</sup></b>					
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>JUN 6, 1913</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>67</b> YRS		# UNDER 1 YEAR MONTHS DAYS		# UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ALLEGANY COUNTY, MD</b>					
10 CITY OR TOWN OF DEATH <b>Cumberland</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SACRED HEART HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		
13a. STATE <b>MD</b>		13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Cumberland</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>74 Eleanor Street</b>			
14 FATHER'S NAME FIRST MIDDLE LAST <b>Unknown</b>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Dora E. Hose</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO		17 INFORMANT ADDRESS <b>Lewis M. Twigg Cumberland, MD Husband</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic ca of ovaries</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>with embolization of femoral</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>arteries</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>7-8</b> 19 <b>80</b> to <b>7-17</b> 19 <b>80</b> that (I) (we) last saw the deceased alive on <b>7-17</b> 19 <b>80</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>John N. Mehan</b>						DEGREE <b>M.D.</b>			22c. DATE SIGNED <b>7-18-80</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOHN N. MEHANNA, M.D.</b>						22e. ADDRESS <b>909-B, SETON DR., CUMBERLAND, MARYLAND 21502</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>7-20-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Pk.</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cumberland Allegany MD</b>			
24 FUNERAL DIRECTOR NAME ADDRESS <b>SCARPELLI FUNERAL HOME, CUMBERLAND, MD. 21502</b>						25a. DATE REC'D. BY REGISTRAR <b>JUL 23 1980</b>			25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

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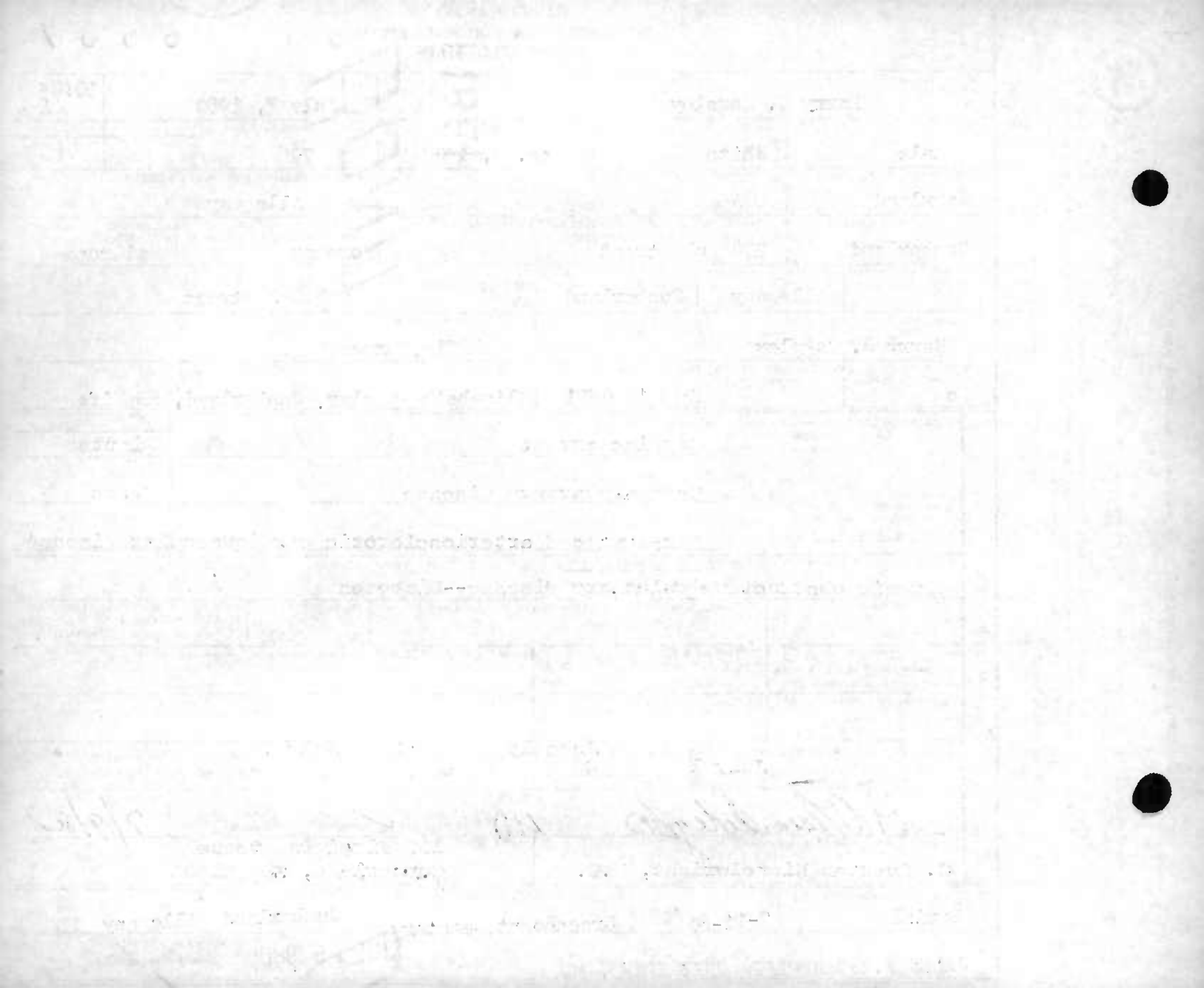
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified apace.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR			8 0 1 6 6 0 7 REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Harry C. Wageley			2a. DATE OF DEATH MONTH DAY YEAR July 7, 1980				2b. HOUR MIN 10:45 A M		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 3, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.			
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 204 Oak Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Foreman		12b. KIND OF BUSINESS OR INDUSTRY Railroad	
13a. STATE MD		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 204 Oak Street	
14. FATHER'S NAME FIRST MIDDLE LAST Harry H. Wageley				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Effie Turner					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			16b. SOCIAL SECURITY NO. 705 14 0571		17. INFORMANT ADDRESS Elizabeth Wageley Cumberland, MD Wife				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> 4/149 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary artery disease</u> (c) <u>Far-advanced arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes Years									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>Chronic obstructive pulmonary disease--Diabetes</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this physician) attended the deceased from <u>June 18</u> , 19 <u>65</u> , to <u>July 7</u> , 19 <u>80</u> , that (I) (lost) saw the deceased alive on <u>July 1</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>G. Overton Himmelwright</i>				DEGREE M.D.				22c. DATE SIGNED 7/9/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G. Overton Himmelwright, M.D.				22e. ADDRESS 133 Virginia Avenue Cumberland, MD 21502					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-11-80		23c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD			
24. FUNERAL DIRECTOR NAME JAMES F. SCARPELLI				ADDRESS CUMBERLAND, MD		25a. DATE REC'D. BY REGISTRAR JUL 15 1980		25b. REGISTRAR'S SIGNATURE <i>Anthony...</i>	

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
15M/7/77

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 8 0 1 6 6 0 8

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2b. DATE KNOWN OF DEATH		ESTI- MATED		MONTH		DAY		YEAR		2d. HOUR																					
Ethel		M		Wagus				7-12-80		7-12-80								1 a.m.																					
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		2d. HOUR																					
Female	White	Dec 6 1903		76 YRS.						7-12-80								5p.m.																					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH																															
West Virginia		USA		WIDOWED		DIVORCED		Allegany																															
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY																																	
Cumberland		Home		Housekeeper-----																																			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																																							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS																															
Maryland		Allegany		Cumberland		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		217 Glenn Street																															
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME																													
FIRST MIDDLE LAST										FIRST MIDDLE LAST																													
William Strite Hedrick										Betty Jane Nelson																													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)										16b. SOCIAL SECURITY NO.										17. INFORMANT																			
No										212-24-2471										Carl U. Mallow																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																													
IMMEDIATE CAUSE (a) Coronary Occlusion										Sudden																													
410 - Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										Coronary Sclerosis										---																			
(b) DUE TO, OR AS A CONSEQUENCE OF																																							
(c) DUE TO, OR AS A CONSEQUENCE OF																																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																																							
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?																			
																				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR										21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)																			
										P.M. 19																													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)										21f. LOCATION																			
																				STREET CITY OR TOWN COUNTY STATE																			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																																							
ACTUAL SIGNATURE										TITLE (SPECIFY)										DATE SIGNED																			
Benedict Skitarelic										M.D. Deputy										7-12-80																			
EXAMINER'S NAME (TYPE OR PRINT)										ADDRESS																													
Benedict Skitarelic, M.D.										R#9, Cumberland, Maryland 21502																													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION CITY OR TOWN COUNTY STATE									
Burial										July 15/80										Hillcrest Burial Park										Cumberland Allegany Maryland									
24. FUNERAL DIRECTOR NAME										ADDRESS										25a. DATE REC'D. BY REGISTRAR										25b. REGISTRAR'S SIGNATURE									
Silcox--Merritt,										Cumberland, Maryland										JUL 16 1980																			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
JESSIE N. WIEBEL								JULY 1, 1980		9:20A	
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS HOURS MIN	
Female		White		July 18, 1902		77 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH				MD.	
W. Va.		U. S. A.				Allegany					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
CUMBERLAND		MEMORIAL		Housewife,		Own Home					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
Maryland		Allegany		Cumberland,				635 Sedgwick St.			
14 FATHER'S NAME FIRST MIDDLE LAST		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16 WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS	
Charles -- Norris		Anna -- Hartley		No,		213-48-0097		Miss Betty L. Aronhalt, Rt. # 5 Box 136		Oakland, Md. 21550	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>asystole</u> <u>1749</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>metastatic adenocarcinoma of breast</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>breast</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>6/14</u> , 19 <u>80</u> , to <u>7/1</u> , 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>7/1</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED					
<u>Thaddeus Elder</u>		MD				July 1, 1980					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
DR. THADDEUS ELDER		MEMORIAL MEDICAL BUILDING CUMBERLAND, MD. 21502									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		7/3/80		St. Luke's Cem.		Cumberland, Allegany Maryland					
24 FUNERAL DIRECTOR NAME ADDRESS		24b. DATE		24c. LOCATION CITY OR TOWN COUNTY STATE		24d. DATE RECEIVED BY REGISTRAR		24e. REGISTRAR'S SIGNATURE			
H. Wayne George 202 Greene St. Cumberland, Md.		21502		JULY 1, 1980							



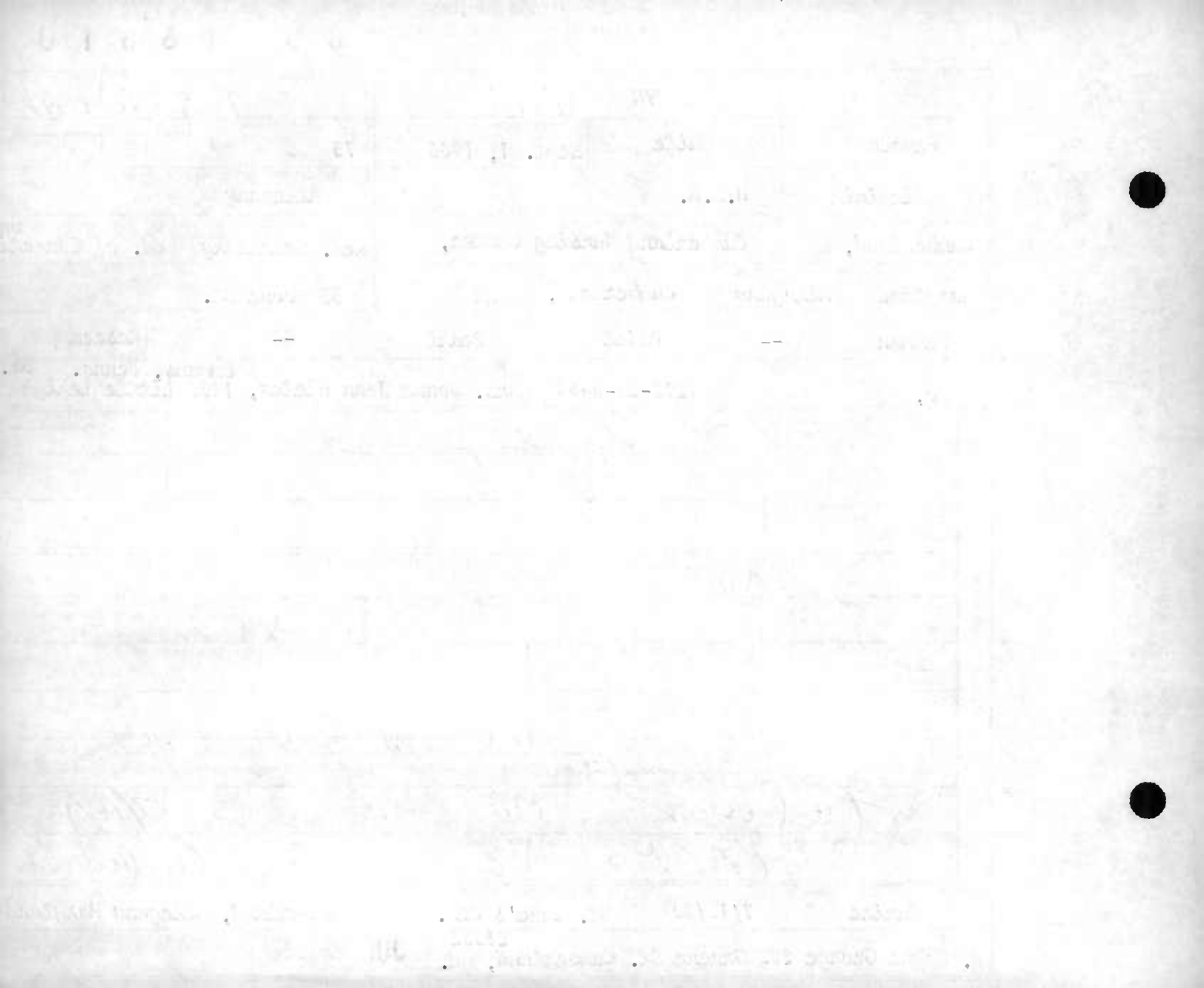


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical examiner, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 0 1 6 6 1 0 REG. NO.							
1. FOR STATE REGISTRAR										2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARY KATHRYN WILSON										7-9-80		8:44 PM					
3. SEX Female			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR Sept. 1, 1906			6. AGE (IN YEARS LAST BIRTHDAY) 73			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.								
10. CITY OR TOWN OF DEATH Cumberland,			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH PLACE, GIVE STREET ADDRESS) Cumberland Nursing Center,			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Secretary			12b. KIND OF BUSINESS OR INDUSTRY Ed. of Educati								
13a. STATE Maryland										13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland,		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 55 Boone St.	
14. FATHER'S NAME FIRST MIDDLE LAST Herman Pafel										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pearl Kas'ecamp							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No,										16b. SOCIAL SECURITY NO. 212-38-5488		17. INFORMANT ADDRESS Emmaus, Penna. Dr. Mrs. Donna Jean Hieter, 1408 Little Lehigh					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 514- IMMEDIATE CAUSE (a) <u>Thyroidal pneumonia.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>4.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>4.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) CAD.																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from <u>7/12</u> 19 <u>80</u> to <u>7/9</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>7/9</u> 19 <u>80</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (and) not view the body after death.																	
22b. SIGNATURE P. L. HALMOS										22c. ADDRESS 302 Sch. St. Cumberland.							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) P. L. HALMOS										22e. ADDRESS 302 Sch. St. Cumberland.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 7/12/80			23c. NAME OF CEMETERY OR CREMATORY St. Luke's Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland, Allegany Maryland								
24. FUNERAL DIRECTOR NAME H. Wayne George 202 Greene St. Cumberland, Md.										25a. DATE REC'D. BY REGISTRAR JUL - 5 1980		25b. REGISTRAR'S SIGNATURE					



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH YOUR FILES, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

Item 18b, Pt. 2. G547 9/3/80 dad DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 8016611			
1. DECEASED NAME (TYPE OR PRINT) <b>Debbie Lee Witt</b>						2a. DATE KNOWN OF DEATH ESTIMATED <b>6 11, 1980</b>		2b. HOUR <b>11a</b>					
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 2, 1949</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>30</b> YRS.		7. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD <b>6 11, 1980</b>		2d. HOUR <b>11a</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD.				
10. CITY OR TOWN OF DEATH <b>Eckhart</b>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Frostburg Memorial Hospital</b>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>none</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Allegany</b>			13c. CITY OR TOWN <b>Eckhart</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS <b>Route 3, box 63</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Ralph Thomas Witt Sr.</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Harriet Louise Humbertson</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>212-78-6990</b>		17. INFORMANT ADDRESS <b>Mrs. Harriet Louise Witt Eckhart, Maryland</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>911-</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>A Asphyxiation</b> (c) <b>B Aspiration of Stomach Contents</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b> <b>please note</b>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <b>Progeria Patient bed fast (midget) with progeria</b>													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion													
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>				TITLE (SPECIFY) <b>Deputy</b>				DATE SIGNED <b>6-11-80</b>					
EXAMINER'S NAME (TYPE OR PRINT) <b>Benedict Skitarelic, M.D.</b>				ADDRESS <b>R#9, Cumberland, Md. 21502</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>June 14 '80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Restlawn Cemetery</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cumberland Allegany Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Durst Funeral Home</b>				ADDRESS <b>57 Frost Ave., Frostburg</b>				25a. DATE REC'D. BY REGISTRAR <b>JUN 19 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Patricia Keeney</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 25M  
(VRA 15, 4) 1/79

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					8 0 1 6 6 1 2 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) MIKAEL J YANTORNO					2a. DATE OF DEATH MONTH DAY YEAR JULY 7, 1980			2b. HOUR 9:30P M		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR August 25 1895		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Italy		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY, MD.				
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Barber		12b. KIND OF BUSINESS OR INDUSTRY Barber Shop		
13a. STATE MD					13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Vincent Yantorno					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carolyn Palermo					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Margaret Molinari Yantorno Cumberland, MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable leukemia, Left Lung with Metastases 1629 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 7/7 1980 to 7/8 1980, that (I) (we) last saw the deceased alive on 7/7 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Calvin Y. Hadidian					DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7/8/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CALVIN Y. HADIDIAN, M.D.					22e. ADDRESS 203 GREENE STREET, CUMBERLAND, MD. 21502					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 7-10-80		23c. NAME OF CEMETERY OR CREMATORY SS. Peter and Paul Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD			
24. FUNERAL DIRECTOR NAME SCARPELLI					24b. ADDRESS 108 VIRGINIA AVE, CUMBERLAND, MD. 21502					

BP

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ALLIANCE COUNTY

SACRED HEART HOSPITAL

303 KENNEDY STREET, CHICAGO, ILL. 60608

CHAS. Y. WOODWARD, M.D.

FOR VINCENNA, IND.  
CHICAGO, ILL. 60608

CHICAGO, ILL.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
15M 7/77

FOR 1- STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 16613			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Virgil Wilson Ziler</b>										2a. DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>July 3, 19 80</b>										2b. HOUR OF DEATH <b>3:30 P. M.</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 29, 1904</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>75 YRS.</b>		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD <b>July 3, 19 80</b>										2d. HOUR <b>3:30 P. M.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b>										MD.	
10. CITY OR TOWN OF DEATH <b>Cumberland</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Memorial Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Driver</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>Bus</b>											
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b> 13b. COUNTY <b>Allegany</b> 13c. CITY OR TOWN <b>Cumberland</b>										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS <b>237 Columbia St.</b>													
14. FATHER'S NAME FIRST MIDDLE LAST <b>John W. Ziler</b>										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Grace M. Bailey</b>													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>217-10-5624</b>				17. INFORMANT <b>Elizabeth R. Ziler</b>				ADDRESS <b>237 Columbia St. Cumberland, Md.</b>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. <b>Coronary Sclerosis</b> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> -----																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																							
ACTUAL SIGNATURE <b>Benedict Skitarolic</b> M.D. TITLE (SPECIFY) <b>Deputy</b> MEDICAL EXAMINER										DATE SIGNED <b>July 3, 1980</b>													
EXAMINER'S NAME (TYPE OR PRINT) <b>Benedict Skitarolic, M.D.</b> ADDRESS <b>Cumberland, Md. 21502</b>																							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>July 7, 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cumberland, Allegany Md.</b>													
24. FUNERAL DIRECTOR NAME ADDRESS <b>Silcox-Merritt Fun. Ser. 404 Decatur St. Cumberland, Md.</b>										25a. DATE REC'D BY REGISTRAR <b>JUL 8 1980</b>				25b. REGISTRAR'S SIGNATURE									



[illegible]